Chapter 1

WELCOME TO CMDP

The Comprehensive Medical and Dental program (CMDP) welcomes you as a provider of health care for Arizona's children in foster care.

The State of Arizona, through the Department of Economic Security (DES), provides comprehensive medical and dental coverage for children placed by DES/Arizona Dept. of Juvenile Corrections or Arizona Juvenile Probation Offices in foster homes, licensed child welfare facilities, the homes of relatives and certified adoptive parents prior to adoption finalization. Children may be placed in Arizona or out-of-state.

CMDP believes that Arizona's commitment to children's health care is an investment in the future of Arizona. Thank you for your help as we work together to provide quality and timely health care services for Arizona's children in foster care.

Program Mission

The Comprehensive Medical and Dental Program promotes the well being of Arizona's children in foster care by ensuring, in partnership with the foster care community, the provision of appropriate and quality health care services.

CMDP's primary objectives are to:

- Proactively respond to the unique health care needs of Arizona's children in foster care.
- Ensure the provision of high quality, clinically appropriate and medically necessary health care, in the most cost effective manner.
- Promote continuity of care and support caregivers, custodians and guardians through integration and coordination of services.

Program Overview

CMDP is a program administered by the DES Division of Children, Youth and Families (DCYF). CMDP provides medical and dental services for children in:

- foster homes;
- the custody of DES and placed with a relative;
- the custody of DES and placed in a certified adoptive home prior to the entry of the final order of adoption;
- the custody of DES and in an independent living program as provided in Arizona Revised Statutes (A.R.S.) § 8-521;
- the custody of a probation department and placed in foster care;
- the custody of DES and placed with an unlicensed non-relative;

CMDP complies with Arizona Health Care Cost Containment System (AHCCCS) regulations to cover children in foster care who are eligible for Medicaid services. In some cases, the court will order additional covered services.

- CMDP covers a full scope of services, ranging from immunizations and prescriptions to surgery and hospitalizations.

- CMDP professional staff and consultants perform consultation, peer review, prior authorization, and utilization and quality management to optimize the delivery of high quality services appropriate to the needs of each child.

- Providers are paid on a fee-for-service basis, according to the AHCCCS Fee-For-Service schedule. CMDP pays provider claims directly for services rendered, regardless of whether the child is placed in Arizona or any other state.

- CMDP members residing in Arizona are assigned a Primary Care Provider (PCP) from providers in CMDP's Preferred Provider Network (PPN). The PPN includes primary care physicians, primary care obstetricians, dentists and selected ancillary providers.

- Providers willing to accept CMDP standards and fee schedules treat members residing out-of-state.

- CMDP is funded with a combination of state funds, federal funds from AHCCCS, Title XIX and Title XXI (KidsCare), and other funds obtained from the coordination of benefits (COB) with third party insurers.

HIPAA Compliance

In 1996, Congress passed into law the Health Insurance Portability and Accountability Act (HIPAA). HIPAA impacts the entire health care industry. The primary objectives of HIPAA are to ensure health insurance portability, reduce health care fraud and abuse, and enforce standards for health information, and guarantee security and privacy of health information. In part, HIPAA is intended to improve the efficiency and effectiveness of the health care system through the establishment of standards, and to protect the security and privacy of health care information.

HIPAA requires that health plans, health care clearinghouses and health care providers comply with requirements pertaining to the use of standardized transaction code sets (TCS), ensure privacy standards are followed, and protect the security of health information.

CMDP has assessed its obligations under HIPAA with a determination that CMDP is performing HIPAA-covered functions. Consequently, CMDP must comply with the applicable HIPAA provisions for privacy, electronic transactions, and security.

Confidentiality of health information for CMDP members has always been of the utmost importance. HIPAA emphasizes the privacy protections, and establishes specific standards for the use and disclosure of protected health information. For information pertaining to CMDP's Privacy Practices or other HIPAA-related information pertaining to CMDP members, you may contact CMDP's Privacy Officer, Margo Amparan as follows:

Attention: CMDP Chief Operations/Information Officer
P.O. Box 29202, Site Code 942C
Phoenix, AZ 85038-9202
Phone: (602) 351-2245 ext. 7010
Email: Mamparan@azdes.gov

If you have questions relating to electronic transactions or TCS, please contact David Gardner, CMDP's Operations Manager at:

Attention: Operations Manager
P.O. Box 29202, Site Code 942C
Phoenix, AZ 85038-9202
Phone: (602) 351-2245 ext. 7057
E-mail: Dgardner@azdes.gov

For more information regarding HIPAA, please see the U.S. Department of Health and Human Services, Office of Civil Rights website: www.hhs.gov/ocr/hipaa or the DES/HIPAA website: www.azdes.gov/hipaa

Additional References: 45 CFR §164.534 and A.R.S.§ 13-3620 (D)

CMDP Provider Manual

The CMDP Provider Manual has been developed to assist you in providing care to CMDP members and obtaining reimbursement. The key to success in any working relationship is good communication between the parties involved. This manual is intended to be a communication tool and reference guide. CMDP is committed to working with our providers and keeping you informed. Staff is always available to assist you.

Provider Services staff function as a liaison between your office and CMDP. We will assist you with any situation that may arise with provider issues. This can include, but is not limited to, keeping you informed of any changes in AHCCCS or CMDP policy and programs, and answering or researching your questions about claims and covered services. We will also assist you in accessing any additional resources you may need for the effective and appropriate medical, dental, and behavioral health treatment of a member.

Member Services staff are available to help you verify eligibility of members and assist in resolving problems with CMDP members who do not keep appointments or follow medical directions. Member Services staff can be reached at extensions 7076, 7078, 7080 and 7083.

CMDP develops and maintains written policies and procedures applicable to each functional area of CMDP. All policies and procedures have been written to implement state and federal laws and regulations as well as AHCCCS rules and policies. The CMDP Provider Manual policies and procedures apply to all contracted and non-contracted providers. A copy of specific CMDP policies is available upon request by calling Provider Services.

The Provider Manual will be updated on an on-going basis. The Provider Services Unit will formally communicate these updates to you.

Unique features of CMDP such as confidentiality, court-ordered treatment, working with members' case managers, members enrolled in other AHCCCS plans, and third party liability are discussed in Chapter 2.

DEPARTMENT OF ECONOMIC SECURITY (DES)
Comprehensive Medical and Dental Program (CMDP)
Site Code 942C P.O. Box 29202
Phoenix, Arizona 85038-9202
(602) 351-2245 (800) 201-1795

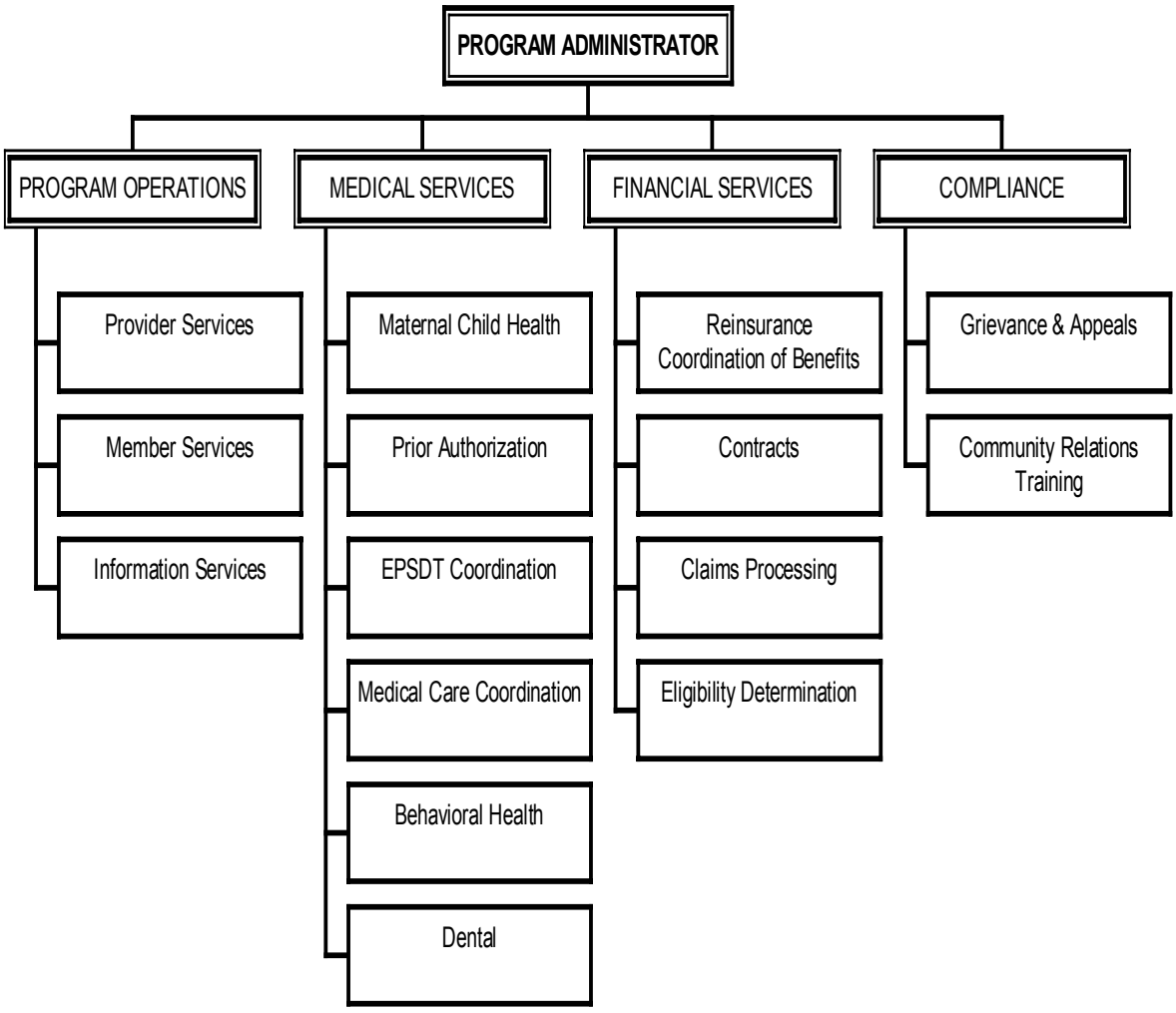
Hospital Notification (800) 544-1746

CUSTOMER SERVICE	**Extension**
Claims Status Inquiry	x7000 x7001
Member Services Member verification, I.D. cards, pharmacy, registered provider information	x7076 x7078 x7080 x7083
Title XIX Eligibility	x7077 x7089 x7098
Provider Services	x7042 x7110 x7112
ADMINISTRATION	
Program Administrator	x7002
Chief Financial Officer	x7107
Compliance Officer	x7011
Community Relations/Training	x7005
Grievances/Policy/HIPAA	x7010
Chief Operations/Information Officer	x7057
MEDICAL & DENTAL SERVICES	
Concurrent Review	x7116
EPSDT/Maternal Child Health Coordinator	x7063
Prior Authorizations/Medical Equipment/Supplies	x7067
Medical Care Coordinator/ Dental Prior Authorization// CRS Services	x7073
Behavioral Health Coordinators:	x7009/x7060
Medical Services Manager	x7070

FAX NUMBERS	
Provider Services	(602) 264-3801
Psychiatric Hospital Notification/Behavioral Health Unit Health	(602) 351-8529
Medical and Dental Services	(602) 351-8529
Administration	(602) 235-9146

CMDP WEBSITE: http://www.azdes.gov/dcyf/cmdpe

CMDP Organization Chart



Chapter 2

UNIQUE FEATURES OF CMDP

All CMDP members have an assigned case manager, parole or probation officer, or a representative from one of the following custodial agencies:

- DES/Child Protective Services (CPS)
- DES/Division of Developmental Disabilities (DDD)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Courts (AOC)/County Juvenile Probation Offices (JPO)
- Casey Family Program

These Case Managers are <u>not</u> Medical Case Managers.

Custodial Agency's Role

The custodial agency is responsible to give consent or to assist with obtaining consent, for treatment of the member (see Chapter 2, Page 4). In some cases, court orders or State laws delegate the responsibility to consent for treatment to the foster caregivers. The Case Manager can provide clarification on a case-by-case basis**. The Case Manager is the child's legal representative and advocate.** The Case Manager can also assist medical providers to access services the child needs. The Case Manager may be able to provide you additional medical history information.

CMDP Provider Services staff can assist you with contacting the child's Case Manager.

Court-Ordered Treatment

The court may dictate specific treatment. The child's Case Manager will inform provider offices of court-ordered treatment, which may include specific timeframes for completion. Bills, on regular claim forms, should be sent to CMDP Claims, Attn: Claims Manager.

CMDP Provider Services can assist you with claims questions.

Confidentiality

All information regarding identification and treatment of CMDP members is confidential (A.R.S. §§ 8-807, 13-362OD, and 41-1959). Information regarding CMDP members, including records and files, may be released to:

- CMDP personnel;
- staff of the custodial agency;
- law enforcement personnel;
- other physicians and treatment staff providing medical services to the member, and foster caregivers.

All requests to the provider for confidential medical information from persons not listed above should be referred to the child's assigned Case Manager.

A provider may not release medical information to anyone not listed above without a signed authorization by the Case Manager or legal guardian.

Authorization for release of information must be a written document, separate from any other document and the signature must be obtained from the designated representative, and must specify the following:

- information or records, in whole or in part, which are authorized for release;
- to whom the release shall be made;
- the period of time for which the authorization is valid, if limited; or
- the dated signature of the designated legal representative.

Providers can use their own medical information release forms.

Dual Enrollment with an AHCCCS Health Plan

Children placed in foster care may be concurrently enrolled in an AHCCCS Health Plan (i.e., APIPA, Mercy Care). During the transition period from the AHCCCS Health Plan to CMDP, the health plan, through its contracted providers, is responsible to provide and reimburse AHCCCS covered medical services provided to the child.

Member Services staff can assist you to identify the health plan the child is enrolled in and whom to call regarding prior authorization and claims submission.

Third Party Liability (TPL)

Third Party Liability means resources available from a person or entity that may be liable to pay part or all of the medical expenses incurred by a CMDP foster child (e.g., the child's birth parents' private insurance. Private insurance of foster parents does NOT cover foster children.) Due to confidentiality regulations, only CMDP shall receive information regarding third party coverage from the member, Case Manager, provider, attorney or AHCCCS.

If you have any questions regarding third party coverage, please contact Provider Services at (602) 351-2245 or (800) 201-1795.

No Co-payment for CMDP Members

CMDP members and foster parents are not responsible for payment of any fees or co-pays. A.R.S. § 36-2903.01 and A.A.C. R6-5-6006 prohibit a provider from charging, submitting a claim to, demanding or otherwise collecting payment from a foster child, a foster parent, a biological parent/relative or any other party as a result of services rendered.

Foster parents are <u>not</u> to be referred to a collections agency at any time.

Consent to Treat

A guardian must give consent for treatment of a CMDP member.

The CMDP member's Case Manager or legal representative must give consent, or obtain consent through the court, for any non-routine service including, but not limited to:

- HIV and/or STD testing;
- pregnancy termination;
- procedures requiring general anesthesia; and
- hospitalizations.

In most cases, the child may give their own consent if thirteen (13) years of age or older for HIV testing. Testing for HIV status must be recommended by a physician and performed to identify the child's medical needs. Testing of infants and children shall take place only when one of the following conditions exists:

- upon recommendation of a physician, when the child displays symptoms or the child or parent presents high risk factors;
- a child is born to a mother who is known to be HIV positive during pregnancy; or
- a child has been involved in sexual activity where an exchange of bodily fluids has likely occurred.

If available, DES shall seek the parent's consent for testing if the child is twelve (12) or under.

Pregnancy terminations must be medically necessary. AHCCCS Medical Policy defines "medically necessary," if one of the following conditions is present:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
    - creating a serious physical or mental health problem for the pregnant member;
    - seriously impairing a bodily function of the pregnant member;
    - causing dysfunction of a bodily organ or part of the pregnant member;
    - exacerbating a health problem of the pregnant member; or
    - preventing the pregnant member from obtaining treatment for a health problem.

The child's Case Manager along with CMDP will assist in obtaining the necessary documentation.

Provider Services staff are always available to assist you in delivering covered services to CMDP members. Effective communication between medical providers and CMDP is essential to the delivery of appropriate medical services to our children. If you have any questions, please call Provider or Medical Services at (602) 351-2245 or (800) 201-1795.

Chapter 3

PROVIDER EXPECTATIONS

CMDP Preferred Provider Network

CMDP has the responsibility of creating and maintaining a physician network, which meets the needs of its members. Primary Care Providers (PCP) are the primary participants in the CMDP Preferred Provider Network (PPN). The PPN also includes Dentists, Obstetricians, other specialists, Behavioral Health Professionals, Pharmacies and selected ancillary service providers and acute care facilities.

CMDP follows a clearly prescribed application process so that all participating providers in the PPN are subject to the same standards and requirements and have access to the same information, and to ensure that all regulatory requirements are met.

Role Of Provider Service Representatives

Provider Service Representatives have three major functions in CMDP. They participate in network development and monitoring activities. They also have roles as both provider educator and advocate and they often serve as the "intermediary" between the provider and other departments within CMDP.

The Provider Service Representatives routinely review information about CMDP's provider network. They work with many other health plan personnel to identify potential areas for network expansion or modification. The Provider Representatives help monitor the services that our network is providing and assist providers in the registration process for CMDP.

Provider Service Representatives are available to provide initial and follow-up training for office staff. They will visit your office regularly to review changes and updates to CMDP policies and procedures, and review specific provider profile information. Representatives also participate in routine site audits and surveys of the provider network to assess compliance with CMDP policies and standards. Please consult with your Provider Service Representative as questions arise. Provider Service Representatives can answer many of your questions directly, research your problem or issue, or help direct you to the proper information resources.

Supplies such as EPSDT forms, dental and vision referral forms, etc. are obtained by contacting your Provider Representative at (602) 351-2245 or (800) 201-1795.

Primary Care Physicians (PCP)

PCP Responsibilities

Primary Care Providers (including, but not limited to, Family Practitioners, General Practitioners, Pediatricians, Internists, Nurse Practitioners or Physician Assistants,) shall conduct their office operation to comply with the following AHCCCS standards:

- PCP shall provide or arrange for covered services to members as defined herein, including emergency medical services, on a twenty-four-hour (24) per day basis, seven (7) days per week.

- PCP shall verify the enrollment and assignment, prior to providing services, via:
  - Medifax
  - AHCCCS website www.ahcccs.state.az.us
  - CMDP Member Services at (602) 351-2245 / (800) 201-1795.

  Failure to verify member enrollment and assignment may result in claim denial.

- Participating PCP means a physician(s), including locum tenens, licensed to practice in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics/gynecology who assumes primary responsibility for supervising, coordinating and providing initial and primary care to members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.

- Primary Care Covered Services refers to basic or general health care traditionally provided by family practice, pediatrics, and internal medicines.

- Primary Care Practitioner means a nurse practitioner or physician's assistant including locum tenens, certified under Arizona law who, as allowed by law, assumes responsibility for supervising, coordinating and providing initial, and primary care to assigned members, initiating referrals for specialty care, follow up of specialty care, and maintaining continuity of care.

- Routine appointments will be available within twenty-one (21) days.

- Emergency appointments will be available the same day.

- Urgent Care appointments will be available within two (2) days.

- It is required each child receive an initial comprehensive examination within thirty (30) days after initial placement in foster care.

Primary Care Providers (including MD/DO, NP and PA) shall conduct their office operation to comply with the following **AHCCCS standards**:

- Office wait time shall not be longer than forty-five (45) minutes from the appointment time, except when the provider is unavailable due to an emergency.

- Phone availability shall be within five (5) rings to answer and less than five (5) minutes on hold after answer.

- After hours care directions may be accessed by:
  - Physician-contracted answering service.
  - Answering recording with a pager number for the physician.
  - Answering machine that pages the physician.

- **Immediate direction of members to the hospital emergency department should be avoided.**

- American with Disabilities Act (ADA) requirements applies when providing services to members with disabilities who may request special accommodations such as interpreters, alternative formats or assistance with physical accessibility.

- Civil Rights Act 1964
  Shall not discriminate against any person on the grounds of race, color, or national origin, or exclude from participation in, be denied of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

- Cultural Competency
  Shall have an awareness and appreciation of customs, values, and beliefs and the ability to incorporate them into the assessment, treatment and interaction with any individual.

- Vaccines For Children Program
  Shall participate in the Vaccines For Children Program. Each year a Provider Profile and Varicella Verification Statement are required for compliance by The Centers for Disease Control and Preventative (CDC) Vaccines For Children (VFC) Program. Forms must be completed and returned to the Arizona Immunization Program annually. If you have any questions, please call the VFC Program at (602) 364-3642.

  - VFC Forms to be completed are:
    - Provider Profile
    - Annual Private/Other Provider Enrollment Form
    - Type of Practice Form
    - Varicella Verification Statement

Medical Records

- AHCCCS requires that the medical records of CMDP members be maintained in a detailed and comprehensive manner with a complete health record for each assigned CMDP member.

- Medical records may be documented on paper or in an electronic format. Records documented on paper must be written legibly in blue or black ink, signed and dated. If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record; whiteout is not allowed. If kept in an electronic file, the provider must establish a method indicating the initiator of information and a method to assure that information is not altered inadvertently. A system must be in place to track when, and by whom, revisions to information are made.

- Medical records should be kept up-to-date, as well as being well organized and comprehensive, with sufficient detail to promote effective patient care and quality review. The PCP must maintain a comprehensive record that incorporates at least these standards:

    - member identification information on each page of the medical record (i.e. name or CMDP Health Plan identification number);
    - documentation of identifying demographics which include name, address, telephone number, CMDP Health Plan identification number, gender, age, date of birth, marital status, next of kin, and if applicable, guardian or authorized representative;
    - signing and dating of documentation for each service provided to the member, by the author who entered information into the member's medical record; if recorded electronically, the author must be identified;
    - legibility of all entries to individuals other than the author;
    - information related to the member's allergies or absence of allergies, and any adverse reactions to medications, if applicable;
    - initial history for children under twenty-one (21) years of age which includes family medical history, social history, prenatal care, birth history, and preventive laboratory screenings;
    - past medical history for all members (for the previous five (5) years if available) which includes disabilities and any previous illnesses or injuries, hospitalizations, surgeries and emergencies;
    - immunization records (required for children; recommended for adult members if available);
    - current medications;
    - current problem list;
    - smoking/ETOH/substance abuse documentation;

- documentation, initialed by the member's PCP to signify review of;
  - diagnostic information including:
    - laboratory tests and screenings (for members requiring obstetric care, the lab screenings must conform to ACOG guidelines);
    - Radiology Reports;
  - physical examination notes; and/or other pertinent data;
  - emergency/urgent care reports;
  - hospital discharge summaries;
  - behavioral health services provided (if applicable);
  - documentation as to whether or not an adult member has completed advance directives;
  - risk assessment tool for obstetric patients (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetrics and Gynecology [ACOG]);
  - documentation related to requests for release of information and subsequent release.
- for each member visit, the medical record must include at least the following:
  - current problem and examination related to the problem;
  - plan of treatment;
  - diagnostic tests with results (if applicable);
  - treatment regimens;
  - scheduled follow-up visits;
  - referrals and results of referrals; and/or
  - ancillary services.
- Forward a copy of requested part(s) of the medical record for an assigned member at the request of CMDP, or upon receipt of a signed release of records form.

- The PCP shall provide to members:
  - office visits during regular office hours;
  - office visits, home visits or other appropriate visits during non-office hours as determined Medically Necessary.

- Assure primary care is available to members twenty-four (24) hours a day, seven days a week. It is the PCP's responsibility to notify CMDP of all providers sharing twenty-four-hour (24) coverage. Each Provider must be AHCCCS registered and credentialed with CMDP. Availability of primary care may be through coverage arrangements with other physicians. The PCP must maintain a method to advise members how to access care twenty-four (24) hours a day.

- Develop a treatment plan for members having a complex or serious medical condition. The treatment plan should involve appropriate medical personnel and be communicated to the CMDP Care Coordination Committee staff to allow their assistance in coordinating covered benefits.

Primary Care Providers (including MD/DO, NP, and PA) shall conduct their office operations to comply with the following **CMDP standards**:

- Maintain continuity of care and reduce duplication of diagnostic procedures, immunizations, medication trials, and specialist consultations by maintaining a complete medical record and forwarding medical records to specialists upon referral.

- Maintain an office that is clean, safe, accessible, and ensures member privacy and confidentiality.

- The PCP shall maintain staff membership and admission privileges in good standing at a given hospital.

- The PCP shall maintain a current DEA number and CMDP encourages the PCP to record the DEA number on all prescriptions.

- The PCP shall have training and experience in his/her respective field(s) of practice, shall be Board Certified/Board Eligible, have completed an approved training program, or be generally recognized by the physician community as being skilled in his/her respective practice.

- The PCP shall provide immunizations and tuberculosis screening (but not immunizations solely for travel) and other measures for the prevention and detection of disease, including instruction in personal healthcare measures, and information on proper and timely use of appropriate medical resources. **All immunizations must be documented in the medical chart and providers are mandated under Arizona Revised Statute (A.R.S. § 36-135) to report all immunizations administered to children from birth through eighteen (18) years of age to the Arizona State Immunizations Information System (ASIIS).** ASIIS also allows providers to access data stored in the registry, thus allowing providers to query the registry for current and historical patient immunization records. If you have any questions, please contact the ASIIS technical support line at (602) 364-3899 or toll free at (877) 491-5741.

- The PCP shall provide Early and Periodic Screening Diagnosis and Treatment (EPSDT) services to members according to the federally mandated EPSDT Periodicity Schedule. Providers must use the AHCCCS EPSDT Tracking Forms to document delivery of EPSDT services (including dental referrals and behavioral health screenings) and send a copy to CMDP attached to the EPSDT claim.

- Children who are HIV positive or who have been diagnosed with AIDS:

    - The PCP shall not deny services to any child on the basis of HIV status.

- Testing for HIV status must be recommended by a physician and performed to identify the children's medical needs. Testing of infants and children shall take place only when one of the following conditions exist:
  - upon recommendation of a physician, when the child displays symptoms or the child or parent presents high risk factors;
  - a child is born to a mother who is known to be HIV positive during pregnancy; or
  - a child has been involved in sexual activity where an exchange of bodily fluids has likely occurred.

- If available, the Division of Children Youth and Families (DCYF) shall seek the parent's consent for testing if the child is twelve (12) years of age or younger. The child may give their own consent if thirteen (13) years of age or older.

- The PCP shall provide the child's medical records, behavioral health records, information relating to the child's condition and treatment, prescription and non-prescription drugs, medications, durable medical equipment, devices and related information to the child's foster parent, group home staff, foster home staff, relative, department employees who are involved in the child's case management and/or any other person or agency in whose care the child is currently placed.

- The PCP shall initiate and follow-up appropriate referrals to Children's Rehabilitation Services (CRS) for (evaluation, follow-up, and treatment services) all members under the age of twenty-one (21) years of age who have been diagnosed with medically eligible CRS diagnoses.

- The PCP shall prescribe and authorize the substitution of generic pharmaceuticals and agree to abide with the CMDP's policies.

EPSDT

Description:

EPSDT services provide comprehensive health care, as defined in A.A.C. R9-22-213 through primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems for eligible AHCCCS members less than twenty-one (21) years of age. EPSDT also provides for all medically necessary services to treat or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT screening, regardless of whether the treatment or service is covered for other Medicaid eligible AHCCCS members twenty-one (21) years of age and older. Limitations and exclusions, other than the requirement for medical necessity, do not apply to EPSDT services.

EPSDT Definitions

***E**arly* – means in the case of an eligible child already with an AHCCCS Health Plan or Program Contractor, as early as possible in the child's life, or in other cases, as soon after the member's eligibility for AHCCCS services has been established.

***P**eriodic* – means at appropriate intervals established by AHCCCS for screening to assure that a condition, illness or injury is not incipient or present.

***S**creening* – means regularly scheduled examinations and evaluation of the general physical and behavioral health, growth, development, and nutritional status of infants, children and youth, and the identification of those in need of more definitive study. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

***D**iagnosis* – means the determination of the nature or cause of a condition, illness or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests and x-rays, when appropriate.

***T**reatment* – means any type of health care or services recognized under the State Plan submitted pursuant to Title XIX of the Social Security Act, to prevent or ameliorate a condition, illness, or injury or prevent or correct abnormalities detected by screening or diagnostic procedures.

EPSDT Service Standards

EPSDT services must be provided according to community standards of practice and the EPSDT periodicity schedule. AHCCCS EPSDT tracking forms must be used to document services provided and comply with AHCCCS standards. An EPSDT exam includes:

- screenings including a comprehensive history unclothed physical exam, hearing and laboratory testing;
- developmental/behavioral health screenings;
- immunizations;
- eye examinations and prescriptive lenses;
- Blood Lead Screening; and
- nutritional assessment and therapy.

Conscious Sedation

CMDP covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while remaining able to continuously maintain adequate cardiovascular and respiratory function as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Dental Services

In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the health plan or program contractor provider network. Covered dental services include:

- Emergency dental services:
  - treatment for pain, infection, swelling and/or injury;
  - extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth; and

- General anesthesia or conscious sedation when local anesthesia is contraindicated or when management of the patient requires it.

- Preventive dental services provided as specified in the EPSDT periodicity schedule:
  - instruction in self-care oral hygiene procedures;
  - complete intraoral examinations;
  - radiology procedures which are screening in nature for diagnosis of dental abnormalities, including panagraph or full-mouth x-rays; supplemental bitewing x-rays; and occlusal or periapical films, as needed;

- oral prophylaxis performed by a dentist or dental hygienist;
- application of topical fluorides (Use of a prophylaxis paste containing fluoride is not considered a separate fluoride treatment);
- dental sealants on all non-carious permanent first and second molars and second primary molars.

- All therapeutic dental services will be covered when they are considered medically necessary but may be subject to prior authorization by CMDP. These services include but are not limited to:
  - periodontal procedures, scaling/root planning, curettage, gingivectomy, osseous surgery;
  - space maintainer when posterior primary teeth are lost prematurely;
  - Crowns:
    - Stainless steel crowns may be used for both primary and permanent posterior teeth; composite, plastic or acrylic crowns must be used for anterior primary teeth;
    - Cast non-precious or semi-precious crowns for members eighteen (18) through twenty (20) years of age may be used on all functional permanent endodontically treated teeth, except third molars;
  - pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar;
  - restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is eighteen (18) through twenty (20) years of age and has had endodontic treatment;
  - dentures, orthodontics and orthognathic surgery when medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan designed by the PCP in consultation with the dentist.

PCP Care Coordination Responsibilities

- Each CMDP member must receive health screening/examination services by their PCP. CMDP PCP's are encouraged to ensure the provision of an initial health screening/examination to members upon assignment to a PCP in order to determine health status and to obtain baseline information.

- CMDP PCPs are responsible for rendering, or ensuring the provision of appropriate preventive and primary care services to the member. These services will include, at a minimum:
    - treatment of routine illness
    - maternity services, if applicable;
    - immunizations;
    - EPSDT screening for eligible members under age twenty-one (21)years;
    - medically necessary treatment for conditions identified in an EPSDT.

- PCPs are accountable for maintaining a medical record which incorporates documentation of all health care services provided to assigned members including PCP services, specialty medical and/or behavioral health services, all medications prescribed by the PCP and/or other providers, authorized DME, dental services, emergency care, and hospitalizations.

- PCPs are also responsible for coordinating the medical care of the CMDP members assigned to them, including at a minimum:
    - oversight of drug regimens to prevent negative interactive effects;
    - follow-up for all emergency services;
    - coordination of inpatient care; and
    - coordination of services provided on a referral basis.

- If your claim for an EPSDT exam is denied for lack of documentation, please resubmit the CMS-1500 with the EPSDT form attached for the date of service.
    - Please include the child's name, DOS and the child's CMDP I.D. number on the EPSDT form.
    - The claim will be paid according to the provider type on the EPSDT form: 100% for MD/DO; 90% for Physician Assistant and Nurse Practitioner, per the AHCCCS fee schedule.
    - Providers shall document all age-specific required information related to EPSDT screenings and visits and must use AHCCCS EPSDT Tracking Forms. EPSDT forms for the various age groups are found on the AHCCCS website, **www.ahcccs.state.az.us**, or may also be obtained through the CMDP Medical Services Unit by calling (602) 351-2245 or (800) 201.1795. **Substitute forms are not acceptable.**

PCP Gatekeeping Responsibilities

Gatekeeping responsibilities include, but are not limited to:

- referring members to contracted specialty providers or hospitals within the health plan or program network, as appropriate;
- if necessary, referring members to out-of network specialty providers;
- assisting CMDP in prior authorization (PA) procedures for members;
- conducting follow-up (and obtaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers and/or hospitals;
- supervision, coordination and provision of care to each assigned member;
- maintaining continuity of care for each assigned member;
- maintaining the member's medical record, including documentation of all services provided to the member by the PCP, as well as any specialty or referral service.

Provider's Additional Responsibilities

- Verify the member's enrollment with CMDP by calling Member Services, Monday - Friday 8:00 a.m. to 5:00 p.m. at (602) 351-2245 ext. 7076, 7078, 7080, or 7083 and after hours at (800) 201-1795.

- Do NOT collect co-payments or payments of any kind from CMDP members, the child's case manager, any fiscal intermediary, the foster child, his/her guardian, his/her estate, the foster child's foster parents, his/her biological parent/relative or any party as a result of services rendered**. Foster parents are not to be referred to collection agencies at any time. (A.A.C. R6-5-6006) and (A.R.S. 36-2903.01)**

- Submit claims as soon as possible to CMDP after service has been provided. See Chapter 7.

- Participation in quality management and utilization review meetings and activities, as scheduled by CMDP.

Appointment Standards

PCP Visits

CMDP members should be seen within twenty-one (**21)** days of referral for a routine appointment. Additionally, members should not be required to wait longer than forty-five (45) minutes after appointment time to be seen in the provider's office. For purposes of this section "urgent" is defined as an acute but not necessarily severe disorder, which, if not attended to, could endanger the patient's health.

CMDP has adopted the following AHCCCS standards by appointment type:

- **Routine** care PCP appointments – within twenty-one (21) days of request.
- **Urgent Care** PCP appointments - within two (2) days of request.
- **Emergency** PCP appointments - same day of request.

It is required each member receive an initial medical examination within thirty (**30**) days after the initial placement in a foster care facility. For Pima and Cochise counties an initial medical examination is required within 14 days of placement.

Referral Procedures

A PCP may refer a member to a contracted/participating specialist by contacting CMDP Provider Services. CMDP will identify specialist(s) within a given area and provide the information to the PCP. The PCP may refer the CMDP member by completing a physician prescription form that includes the following information:

- Provider's Name, address, phone number and specialty.
- Date of Appointment.
- Reason for the Referral.

When needed, CMDP will provide assistance to members in selecting a specialist by calling a CMDP Provider Services Representative at (602) 351-2245 or (800) 201-1795.

Specialty Referrals

- Emergency appointments will be available within twenty-four (24) hours of referral.
- Urgent care appointments will be available within three (3) days of referral.
- Routine appointments will be available within forty-five (45) days of referral.

If a child needs to see a specialist, the child's PCP can refer to a specialist participating in the PPN. Providers can obtain a PPN list from their CMDP Provider Representative. Call Prior Authorization, (602) 351-2245 ext. 7067 or (800) 201-1795, to receive prior authorization to refer to a non-PPN specialist.

EPSDT Appointment Availability

The AHCCCS EPSDT Periodicity Schedule (located at the end of Chapter 5) describes at what age children should be seen for preventive care and which medical screens are required at each age. PCPs are requested to perform the services within the time frames outlined on the Periodicity Schedule. This includes performing the newborn visit within fourteen (14) days of the baby's birth.

CMDP encourages all providers to schedule the next periodic screen at the current office visit, particularly for children twenty-four (24) months of age and younger.

Providers are to utilize the standardized AHCCCS EPSDT Tracking Forms.

Dental Appointments

- Emergency appointments will be available within twenty-four (24) hours of request.
- Urgent care appointments will be available within three (3) days of request.
- Routine appointments will be available within forty-five (45) days of request. (See section on dental coverage.)

Prenatal Care Appointments

- First trimester appointments will be available within fourteen (14) days of request.
- Second trimester appointments will be available within seven (7) days of request.
- Third trimester appointments will be available within three (3) days of request.
- Appointments for high-risk pregnancies will be available within three (3) days of identification of high risk to the maternity care provider, or immediately if an emergency exist.

PLEASE NOTE: Pregnant CMDP members are considered high risk, due to their age. Consequently, the high-risk appointment standard of three (3) days, from diagnosis of the pregnancy, must be maintained.

Network physicians and practitioners will adhere to the American College of Obstetrician and Gynecologists (ACOG) standards of care including the use of a standardized medical risk assessment tool and ongoing risk assessment.

In the case of pregnancy, the member's provider should confirm the pregnancy and request a referral to an obstetrics (OB) doctor. The OB requests a prior authorization from CMDP for PA to start a schedule of regular checkups to make sure the pregnancy is going well. If there are any special health care needs, the OB doctor calls CMDP prior authorization to refer to a specialist.

Pregnancy terminations must be medically necessary. AHCCCS Medical Policy defines necessary, if one of the following conditions is present:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- If the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities is required. This consists of the name of the agency to which it was reported, the report number if available and the date the report was filed.
- The pregnancy termination is medically necessary according to the medical judgment of a license physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
  - Creating a serious physical or mental health problem for the pregnant member
  - Seriously impairing a bodily function of the pregnant member
  - Causing dysfunction of a bodily organ or part of the pregnant member.
  - Exacerbating a health problem of the pregnant member: or
  - Preventing the pregnant member from obtaining treatment for a health problem.

The child's Case Manager along with CMDP will assist in obtaining the necessary documentation.

The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination. The Certificate must certify that in the physician's professional judgment, one or more of the above criteria has been met.

Unless a life-threatening emergency exists, a provider must obtain CMDP's approval and a court order before doing the procedure. (Please see Chapter 2: Unique Features of CMDP [Court Ordered Treatment]).

Behavioral Health Service Appointments

- Emergency appointments will be available within twenty-four (24) hours of request.
- Non-emergency appointments will be available within seven (7) days of request.
- Member waiting times at provider offices should not exceed forty-five (45) minutes from the appointment time except when the provider is unavailable because of an emergency.

Missed or Canceled Appointments

One of CMDP's priorities is to assist members to keep appointments with their PCP, specialty, and ancillary providers. You are encouraged to notify Member Services at (602) 351-2245 or (800) 201-1795 if a member continually misses or cancels appointments without rescheduling them.

If a pregnant member misses two consecutive prenatal care appointments the Primary Care Obstetrician (PCO) should notify the Maternal Child Health Coordinator at (602) 351-2245 ext 7063 or (800) 201-1795.

Provider Registration

As a medical professional that is interested in registering with CMDP it will be necessary to comply with CMDP policies and procedures for provider participation. Out-of-state providers also must register with AHCCCS to be reimbursed for covered services provided to CMDP members.

Providers are required to:

- complete an application;
- sign a provider agreement;
- sign all applicable forms; and
- submit documentation of their applicable licenses and/or certificates

Information and registration materials may be obtained by calling CMDP Provider Registration Unit at (602) 351-2245 or (800) 201-1795

Because most foster children are eligible for funding through the Arizona Health Care Cost Containment System (AHCCCS), CMDP must register providers using the AHCCCS Provider Registration Packet (included at the end of this section). Although providers are required to register with CMDP using the AHCCCS Provider Packet, they are **not** required to see AHCCCS clients outside of CMDP. CMDP verifies the provider is in AHCCCS by querying the AHCCCS database, if the provider is not in the AHCCCS database, a registration packet is sent.

Once the completed Provider Registration packet has been received and approved by AHCCCS, CMDP will enter the provider's AHCCCS identification number into the CMDP computer, after verifying provider status in AHCCCS database. This ID#, must be used on all correspondence and claims submitted to CMDP. When the provider is a member of a group practice, the individuals who make up the group practice must each be listed on the CMDP/AHCCCS Provider Registration form in order for CMDP to use the AHCCCS provider identification number for each of them. Inclusion of current licensing information and signatures in all indicated areas in the packet are required in order for the packet to be considered complete.

CMDP must be notified of all name changes, address changes, or changes in tax identification numbers.

Provider Termination from CMDP

Registration with CMDP will be terminated if the provider's license to practice in the State of Arizona or residing state is:

- Revoked,
- Limited,
- Suspended, or
- Placed on probationary status or otherwise diminished.

CMDP providers must notify Provider Services at least thirty (30) days prior to any:

- Change,
- Cancellation, or
- Termination of their professional malpractice insurance coverage, and
- Within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against them.

CMDP or any registered provider may terminate association, with or without cause, upon providing thirty (30) days written notice to the other party of intent to terminate the association. (Those providers who have not provided services to a foster child within a twenty-four (24) month period may also be terminated).

CMDP Support

The following is a summary of the ways in which CMDP staff assist and support providers:

1. assist in management of difficult, non-compliant members;
2. provide assistance/mediation regarding member, provider or agency concerns;
3. act as liaison with the member's agency representative in order to obtain health care history and or legal consent to perform procedures;
4. facilitating of "clean" claims for authorized services within 30 days;
5. provide information regarding referrals to CMDP registered providers;
6. assist with member referrals to community programs (e.g. CRS, RBHA, AzEIP);
7. perform inpatient reviews;
8. coordinate medical care for at risk children;
9. facilitate prior authorization for urgent conditions within 24 hours and for non-urgent conditions within seven working days;
10. process all informal and formal grievances for members and providers;
11. conduct periodic site and chart reviews;

CMDP Provider Services staff is always available to assist you to deliver covered services to CMDP members. Effective communication between medical providers and CMDP is essential to the delivery of appropriate medical services to our children. Please call us if you have any questions.

CHAPTER APPENDIX

Provider Registration Packet

Information/Instruction

Enrollment Forms

Chapter 4

MEMBER SERVICES

Introduction To CMDP Member Services

The Member Services Department serves as the coordinating unit for all member activities. Member Services provides assistance to members, foster caregivers, and custodial agency representatives. This department assists with eligibility and enrollment problems, assists with accessing medical care, answers benefit questions, and assigns and changes primary care physicians. Contact Member Services at (602) 351-2245 or (800) 201-1795 for assistance.

Language Line Services:

Language Line automated access offers a fast and efficient way to connect to a professional interpreter; anytime, anywhere. This service provides interpretation in over 140 languages as well as written translation. This service is provided to CMDP members only. To access this service please call CMDP Provider Services at (602) 351-2245 ext. 7042 or (800) 201-1795.

Member Enrollment Packets

CMDP complies with AHCCCS policy to communicate with new members by mailing a New Member Enrollment Packet to all new members.

Because CMDP members are age 0-21 years, New Member Enrollment Packets will be mailed in care of the foster caregiver (foster parent, group home staff, adult relative, etc.) or to the custodial agency case manager.

The New Member Packet consists of:

- Welcome Letter
- CMDP Member Handbook
- CMDP Member ID Card
- Provider Directory
- EPSDT Notice
- Family Planning Notification letter (age appropriate)
- Member Health Risk Assessment
- Notice of Privacy Practices
- Pharmacy Benefits Management Notice

PCP Assignment

CMDP assigns a Primary Care Physician (PCP) to all members. PCPs are Family Practitioners, General Practitioners, Pediatricians, Internists, Nurse Practitioners, or Physician Assistants. A specialty physician may be assigned as a PCP depending upon the member's medical condition.

Most PCPs have agreed to participate in the CMDP Preferred Provider Network (PPN). PCPs in the PPN will be the first choice for assignment if the member does not make a choice.

Members are given an opportunity to choose a PCP. If a choice, is not made PCPs are assigned based on the office location's proximity to the zip code of the member's placement.

CMDP Member ID Cards

ID cards are included in the member's new enrollment packet and mailed in care of the custodial agency case manager, or the foster caregiver, within five (5) days of enrollment. This card includes the member's name and identification number. Providers should request to see the member's ID card each time the member presents for service. If the member does not have their card available at the time of service, they may not be denied treatment. Call Member Services to verify enrollment. The ID card does not guarantee enrollment.

The CMDP ID is not the same as the AHCCCS ID #. Make a copy of the member's CMDP ID Card to ensure use of the correct CMDP ID #.

Other means of identification for a CMDP member may include:

- A Generic ID card presented by the CPS Case Manager, emergency receiving home or shelter. This ID card is used to identify the member prior to receipt of their own ID card. Call CMDP Member Services during business hours to obtain the Member ID # to submit on your claim.

A foster caregiver may present a Notice to Provider Form, in lieu of the member's ID card. A sample of this form is included at the end of this chapter. This form contains the member's name and ID #.

Sample of CMDP Member ID card:

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Comprehensive Medical and Dental Program, 942C
P.O. Box 29202 Phoenix, Arizona 85038-9202

COMPREHENSIVE MEDICAL & DENTAL PROGRAM
IDENTIFICATION CARDS

To the Case Manager: Attached are two (2) CMDP ID cards for one child in your caseload.

Please detach one card and give it to the foster family caring for the child. Retain the second card to keep in your file for safekeeping, just in case the first card is lost or destroyed.

Please give this ID card to the child's family as soon as possible. The child's doctor and pharmacy need the information contained on the card before they can submit a claim to CMDP.

If you have any questions or need more information call CMDP's Member Services Unit at: (602) 351-2245 ext 7080, 7083, 7076,7078 or (800) 201-1795.
Notes:_____
_____
_____
_____
_____

Front of ID Card:

COMPREHENSIVE MEDICAL & DENTAL PROGRAM
Arizona Department of Economic Security
P.O. Box 29202 (942C) Phoenix, AZ 85038-9202
(602) 351-2245 (800) 201-1795

Member: _____

DOB: _____ ID#: _____

Pharmacy Helpline: **(800) 207-2568**
WHP HEALTH INITIATIVES, INC.
Do not charge co-pays or any other charges. Bill CMDP

Back of ID Card:

Claims: Send CMS 1500, UB92 or ADA claim form to address on front of card. Reimbursement is according to AZ Medicaid fee schedule, if member is eligible on date of service.

Pharmacy: Present card to participating pharmacy. Walgreen's Health Initiatives is not responsible for payment of claims at non-participating pharmacy. RxGrp: 752212. RxBIN: 603286 RxPCN: 01410000

Emergency Services: Provide services and call (800) 544-1746 within 12 hours of service.

All Other Medical Services: Call (800) 201-1795 for authorization PRIOR to service delivery.

Dual Eligibility

AHCCCS members who are eligible for Medicare and Medicaid (AHCCCS) services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible. QMB eligible members receive coverage for all Medicaid services and include:

- Impatient Psychiatry,
- Psychology,
- Respite and,
- Chiropractic Services.

QMB and Non-QMB members must use health care providers registered with CMDP.

Other Insurance

If a child comes into foster care with prior health insurance, CMDP is the payer of last resort. Any other insurance coverage a member has should pay for medical care before CMDP pays. The member and the custodial agency (CPS, JPO, ADJC) should inform CMDP of any other insurance the member has at enrollment.

Member Grievances

Grievance is defined as an expression of dissatisfaction about any matter other than an action.

Action can be defined as any of the following:

- Denial or limited authorization of a requested service, including type or level of service.
- The reduction, suspension or termination of a previously authorized service.
- The denial, in whole or part, of payment for a service.
- Failure to provide a service in a timely manner as set forth in the AHCCCS contract.
- Failure of CMDP to act within the timeframe specified in the Arizona Administrative Code, Title 9, Chapter 34, Article 2, *Appeal, Grievance and Hearing for an Enrolled Person.*

CMDP will attempt to take immediate action to assist the member, foster caregiver and/or custodial agency or authorized representative in resolving the grievance. When an immediate resolution is not possible and the dispute is not of a clinical nature, a resolution will be obtained within ninety (90) days after the day the grievance was received. Grievances regarding an action are forwarded to the Grievance Manager who works in conjunction with the Medical Services clinical staff to obtain a resolution. The enrollee and/or authorized representative must file an appeal either orally or in writing with CMDP within sixty (60) days after the date of the Notice of Action. If you have any questions regarding a Member grievance please contact the Grievance Manager at (602) 351-2245 ext. 7010.

CMDP reviews member grievances data to help identify service issues and make improvements in quality of care and service. Member satisfaction is dependent upon your cooperation with these activities. Our goal is to work in partnership with you to maintain member satisfaction.

Member grievances can be submitted in writing and can be mailed, hand delivered or faxed to:

Department of Economic Security
Comprehensive Medical and Dental Program
Attention: Grievance Manager
P.O. Box 29202
3225 N. Central Ave., Suite 1000
Phoenix, AZ 85038-9202
Fax: (602) 235-9146

Verifying Member Enrollment

If you have any question about member identification, please contact CMDP Member Services at (602) 351-2245 or (800) 201-1795.

When calling Member Services to verify enrollment, please have the member's ID number, name and date of birth. Document the enrollment verification information you receive over the telephone including the name of the Member Service's Representative, date and time of call.

CHAPTER APPENDIX

FC06900 Notice to Provider (Medical)

Chapter 5

MEDICAL SERVICES

The Comprehensive Medical and Dental Program provides full coverage for medical and dental services necessary to achieve and maintain the optimal level of health for children in foster care. Covered services are based upon a determination of medical necessity and clinical appropriateness.

Peer Review

The Peer Review process is conducted as a supportive process to improve quality of medical care and services provided to CMDP members. The Peer Review process is under the leadership of the Quality Management Committee Chairperson (Medical Director) and is conducted under applicable state and federal laws and protected by the immunity and confidentiality provisions of these laws.

CMDP's Peer Review process focuses on the issue identified and, with the Quality Management (QM) Department, integrate utilization management, quality issues, medical necessity, cost, and case management.

CMDP providers are responsible for delivering medically necessary services to members, in compliance with AHCCCS and other appropriate guidelines. CMDP reviews potential quality of care issues by utilizing the Peer Review process. The QM Committee in executive session evaluates potential quality of care issues and makes recommendations. These recommendations may include, but are not limited to, corrective action plans, and external peer review and/or provider disciplinary action. A provider may appeal a decision or recommendation, made by the QM Committee, to reduce, suspend, or deny provider privileges. The provider may request a review of the QM Committee's decision by filing a grievance or an appeal with CMDP.

Should you have any questions regarding the Peer Review process, please contact the Medical Services Department.

Covered Services

Covered services include, but are not limited to, the following acute medical services:

- Behavioral Health Services for children who are not eligible to receive AHCCCS (Title XIX or Title XXI) funded services through the Regional Behavioral Health Authority (RBHA) system.
- Chiropractic services with a referral from the primary provider.
- Dental Services
- Dialysis
- Early and periodic screening, diagnosis and treatment services (EPSDT)
- Emergency ambulance
- Emergency Medical Services
- Eye Examinations/Optometry Services
- Family Planning, including medications and supplies, provided to delay or prevent pregnancy. Does not include IUD systems.
- Health Risk Assessment and Screening Tests
- Home Health Services
- Home Health Services in lieu of hospitalization
- Hospice
- Hospital Inpatient Services
  Hospital accommodation, and appropriate staffing, supplies, equipment and services for:
  - Routine care
  - Intensive care
  - Neonatal intensive care
  - Maternity care including labor, delivery and recovery rooms, and related services
  - Surgery and anesthesiology services
  - Acute Behavioral Health emergency/crisis stabilization
  - Medical supplies, appliances and equipment consistent with the level of accommodation
- Immunizations
- Initial consultations/evaluations
- Laboratory, X-ray and medical imaging services
- Maternal and child health services
- Medical Foods
- Medical supplies, durable medical equipment and prosthetic devices
- Medically necessary transportation
- Outpatient health services
- Nursing facility services in lieu of hospitalization
- Pharmacy services
- Physician services
- Podiatry services
- Therapies which include physical, occupational, respiratory, audiology and speech therapies

Non-Covered Services

CMDP **will not** reimburse providers for the following expenses:

- Care or services not required for the prevention, diagnosis or treatment of a condition, illness or injury. This includes routine drug testing for non-medical reasons.
- Non-medical items such as shampoo, haircuts and mouthwash. Diapers are not covered.
- Dietary formulas or formula type diet supplements are not covered (*unless they are deemed medically necessary through the prior authorization process*). Equipment for tube feedings is covered.
- Services for which no charge would have been rendered in the absence of this program.
- Outpatient or inpatient psychological or other counseling services provided to AHCCCS eligible foster children residing in Arizona. These services are provided through the Regional Behavioral Health Authorities (RBHA).
- Expenses for cosmetic services or devices that are not medically necessary, such as newborn circumcisions.
- That portion of the cost of any covered service, which exceeds allowable charges in the CMDP fee schedule. Determination and payment **shall represent PAYMENT IN FULL for the services rendered. Any additional charge is prohibited and will not be paid.**
- Services which required prior authorization or notification when such authorization was not obtained or was denied.
- The cost of care, services or items in excess of that paid by other programs.
- Services for which claims have not been re-submitted within twelve (12) months of the date of service.
- Non-spontaneous pregnancy termination procedures, including referrals to physicians or agencies that offer these procedures or for related counseling.
- Intrauterine Device (IUD) is not a covered service.
- Care provided by individuals who are not properly licensed and/or certified.
- Services of naturopaths.
- Services determined by AHCCCS to be experimental or provided primarily for the purpose of research, such as vision therapy.
- Treatment of the basic conditions of alcoholism and drug addiction. Alcohol and substance abuse treatment is an AHCCCS covered service that AHCCCS eligible members should receive from the Regional Behavioral Health Authority.
- Medical services provided to a person who is considered to be an inmate of a public institution.

PRIOR AUTHORIZATION (PA) MATRIX

Service Type	PA Required	PA Not Required
Ancillary Therapy	OT, PT, Speech, Respiratory and Chiropractic Services. Number of visits cannot exceed patient's eligibility span.	
Consultation		Initial Consultation requires referral from PCP. Does not require PA.
Initial treatment	Documentation for PA includes the written evaluation and plan of care. Number of visits cannot exceed patient's eligibility span. Proof of PCP referral must accompany the request.	
Continued treatment	Documentation for PA includes the written evaluation and plan of care. Number of visits cannot exceed patient's eligibility span.	
Behavioral Health		
Consultation	Requires PA to determine if patient is enrolled or eligible to receive services from Regional Behavioral Health Authority (RBHA).	
Inpatient	Requires PA to determine if patient is enrolled or eligible to receive services from Regional Behavioral Health Authority (RBHA). **CMDP must be notified within 24 hours of admission.**	
Outpatient	Requires PA to determine if patient is enrolled or eligible to receive services from Regional Behavioral Health Authority (RBHA). Psychological testing requires PA and documentation to support medical necessity of an acute or chronic brain disorder.	
Psychotropic Prescriptions	Prescriptions from Regional Behavioral Health Authority providers (RBHA) should be filled at RBHA contracted pharmacies.	PCP may write prescriptions for patients with minor depression, anxiety disorders and treatment of ADD/ADHD without co-morbidity.
Service Type	**PA Required**	**PA Not Required**

Service Type	PA Required	PA Not Required
SSRI Category Prozac (fluoxetine) Paxil (paroxetine) Zoloft Celexa Lexapro Luvox(fluvoxamine) Sarefem	Medications to treat major depressive disorders. Requires PA. Medication provided by the RBHA for eligible members. A 30-day supply will be dispensed once to ensure un-interrupted service.	These medications should be prescribed and monitored by an appropriately trained behavioral health provider and dispensed at a BHA pharmacy, if RBHA eligible.
Circumcision	Circumcision is a covered service when **medically necessary** requires PA and documentation to support medical necessity.	
Dental		Routine and preventive dental services do not require PA. Emergency services to relieve pain, suffering or infection, do not require PA. May be retrospectively reviewed.
Oral Surgery	Requires documentation to support medical necessity.	
Orthodontics	Submit documentation to support medical necessity. Include X-rays, tracings, and models to substantiate medical necessity.	
Orthognathic surgery	PA required to determine if patient is CRS enrolled or eligible.	
Other Dental: Periodontal procedures, bridge & crown restoration, root canals	PA required. Must submit documentation to support medical necessity.	
Diagnostic Testing	PA required for diagnostic tests valued at $250 or more. Cardiac and genetic testing requires PA. If unsure, verify PA necessity by contacting Medical Services.	**HIV tests require signed consent by the child's custodial agency if the child is 12 years of age or younger, 13 + child may consent.** HIV/AIDS testing does not require PA.
Dialysis	Requires PA. Proof of PCP referral must accompany request. Must submit documentation to support medical necessity. Number of visits cannot exceed patient's eligibility span.	Initial consultation requires referral from PCP.
Service Type	**PA Required**	**PA Not Required**

Service Type	PA Required	PA Not Required
Durable Medical Equipment (DME) and Supplies; Prosthetics and Orthotics	PA required for all rentals. Total cost of the rentals must not exceed the purchase price. Purchases valued at $300 or more require PA. Nutritional supplements/formulas require PA.	Medically necessary items following hospital discharge for a period of 30 days or less and equipment ordered on an emergency basis do not require PA.
Emergency Room and Urgent Care Services	**CMDP must be notified within 12 hours of service.**	
Inpatient Services	**CMDP must be notified within 24 hours of admission.** PA covers treatment and consultation provided during the admission.	The child's custodial agency must sign as the legal guardian.
Obstetrical Services	PA and ACOG Health Record required for OB package. OB package includes: prenatal visits, 2 ultrasounds, delivery and postpartum visit. Any further testing requires PA.	
Stress Testing	Requires PA and documentation to support medical necessity.	
CVS	Requires PA and documentation to support medical necessity.	
Amniocentesis	Requires PA and documentation to support medical necessity.	
Pregnancy Termination	Requires PA and must meet AHCCCS guidelines and have proper documentation to support the request.	**The child's custodial agency must sign as the legal guardian.**
Oncology Treatment		Initial consultation requires referral from PCP.
Chemotherapy	Requires PA and documentation, from the Oncologist, to support medical necessity.	
Radiation	Requires PA and documentation, from the Oncologist, to support medical necessity.	
Outpatient Services	**See next page**	
Service Type	**PA Required**	**PA Not Required**

Service Type	PA Required	PA Not Required
Family Planning	PA required for surgical interventions.	Birth control supplies, including oral and over the counter, do not require a PA. STD and HIV/AIDS testing does not require a PA **but the child's custodial agency must sign for consent.**
Home Health/Hospice	Requires PA and documentation to support medical necessity. Written plan of care must accompany the request.	If referred to a specialist, the initial consultation requires referral from PCP.
Specialist Referrals	Treatment beyond the initial consultation requires PA. Include documentation to support medical necessity and plan of care.	Initial consultation does not require PA, but obtain referral from child's PCP.
Pharmacy		Must be ordered by a physician and written on a prescription.
Synagis and Growth Hormones, DDAVP, Xolair and Accutane	Requires PA and documentation to support medical necessity. The CMDP Pharmacy Benefits Management (PBM) Company, Walgreens Health Initiatives (WHI), dispenses both medications.	
Psychotropic Medications	See *Behavioral Health* section regarding : Prozac (fluoxetine), Paxil (paroxetine), Zoloft, Celexa, Lexapro, Luvox (fluvoxamine) or Sarefem	
Over the Counter Medications (OTC)	Requires PA and documentation to support medical necessity and must be written on a prescription from a provider. Diapers, vitamins and over the counter analgesics are not covered.	
Surgery		**The child's custodial agency must sign as the legal guardian.**
In-office	Requires PA for surgical treatments.	Initial consultation requires referral from PCP. Initial consultation does not require PA.
Inpatient	Requires PA if the surgical procedure is not anticipated at the time of admission or is not related to the admitting diagnosis.	Any emergent surgery does not require a separate PA.
Outpatient	Requires PA and documentation to support medical necessity. The facility must obtain a separate PA. Anesthesia is included unless billed separately.	Any emergent surgery does not require a PA. Notify CMDP within 24 hours and documentation must be submitted for review.
Service Type	**PA Required**	**PA Not Required**

Service Type	PA Required	PA Not Required
Transplants	Requires PA and documentation to support medical necessity. All evaluations and plans of care must be included. CMDP collaborates with the AHCCCS Transplant Coordinator for coordination of services.	
Transportation		
Emergency	**CMDP Must be notified within 10 days of service.**	
Medically Necessary-Non Emergent	Notify Member Services for arrangements and authorization. An adult must accompany the child.	
Vision Services		
Eyeglasses	Tinted lenses require PA and documentation to support medical necessity.	Frames, lenses and scratch coating do not require a PA, if the cost is within the maximum of the AHCCCS Fee Schedule. Bifocals and repairs do not require a PA.
Contact Lenses	Requires PA and documentation to support medical necessity.	
Service Type	**PA Required**	**PA Not Required**

Behavioral Health

Eligibility for Services:

AHCCCS (Title XIX) and KidsCare/AHCCCS (Title XXI members) can receive behavioral health services through the CMDP Primary Care Provider (PCP), or Regional Behavioral Health Authority (RBHA) in their county of residence. The CMDP PCP can prescribe psychotropic medications for disorders of mild depression, anxiety disorder and Attention Deficit-Hyperactivity Disorders (without co-morbidity), if the PCP is going to provide the ongoing monitoring for these members. Members may also receive behavioral health services through the RBHA for these same disorders. If the member has a psychiatric condition outside one of the disorders listed above, requires counseling, has co-morbidity, requires two or more psychiatric medications, or requires consultation from a psychiatrist, the patient must be referred to the RBHA for behavioral health services or appropriate medications.

AHCCCS eligible members who are placed of the State of Arizona for treatment purposes as arranged by the RBHA and have previously been enrolled in one of Arizona RBHA's receive Behavioral Health services through the RBHA's contracted providers in the child's last Arizona county of residence.

Non-AHCCCS eligible (Non Title XIX/XXI) members receive medically necessary services directly through CMDP registered behavioral health providers. A prior authorization is necessary, as the CMDP Behavioral Health coordinators must assist in arranging these services. These services are regularly reviewed by CMDP to assure appropriate level of care, least restrictive guidelines, and quality. Additional Behavioral Health services may be provided by the custodial agencies, such as CPS. CMDP provides medically necessary Behavioral Health services for non-AHCCCS eligible members in foster placement outside the State of Arizona.

Psychotropic Medications**:**

Psychotropic medications may be prescribed and monitored by the member's PCP and reimbursed by CMDP for symptoms and mental health diagnoses of mild depressive disorders, anxiety disorders, and attention-deficit/hyperactivity disorders without co-morbidity. When the PCP is managing one of the above medical conditions, it is not necessary to refer the member to a RBHA or a psychiatrist. Medications prescribed by the PCP, for AHCCCS and non-AHCCCS members should be filled by a CMDP contracted pharmacy.

If a RBHA provider has prescribed a behavioral health medication for an AHCCCS (Title XIX) or KidsCare/AHCCCS (Title XXI) member, this medication must be filled by a RBHA contracted pharmacy.

The CMDP Behavioral Health Coordinator's Role

CMDP Behavioral Health Coordinators are responsible for:

- Assisting providers in accessing Behavioral Health services for which their patients may be eligible.
- Communicating with custodial Case Managers, Probation/Parole Officers, and DCYF Mental Health Specialists regarding the delivery of Behavioral Health services to CMDP members, including psychotropic medication monitoring.
- Assisting Case Managers in arranging for covered services for CMDP members who are placed out of state.
- Arranging covered services for non-Medicaid eligible CMDP members in Arizona who require Behavioral Health services.
- Monitoring inpatient hospital stays of all members.
- Communicating service plan information from Behavioral Health professionals to PCPs.

CMDP BEHAVIORAL HEALTH COORDINATORS
Annette Sims or Lynda Correia (602) 351-2245 x7009 or 7060
Out of County (800) 201-1795

To notify CMDP after hours, contact the Notification number at (800) 544-1746

Behavioral Health General Information

The following sections contain useful information for providers, regardless of member eligibility category.

Intake Standards

All Behavioral Health professionals are requested to adhere to the following AHCCCS mandated standards:

- Children presenting for inpatient hospitalization or emergency services must be assessed within twenty-four (24) hours of notification of the emergency.
- Children referred for non-emergent services must be assessed within seven days of the referral.

AHCCCS (Title XIX) and Kids Care (Title XXI) Members

Referrals

The member's custodial Case Manager or Probation/Parole Officer can assist you in making a Behavioral Health referral to the RBHA. Anyone can refer the member to a RBHA; however, the custodial Case Managers are familiar with the process and will be glad to assist. If you have any questions about how to contact the child's Case Manager (Probation/Parole Officer), or need assistance in making a referral, please contact the CMDP Behavioral Health Coordinators.

Services

Behavioral Health services provided through the RBHA's may include the following services

1) Inpatient psychiatric facility admission
2) Screening
3) Evaluation and diagnosis
4) Individual therapy and counseling
5) Group and/or family therapy and counseling
6) Psychotropic medication, adjustment and monitoring
7) Living Skills Training
8) Health Promotion
9) Personal Assistance
10) Children's intensive case management (CICM)
11) Laboratory and radiology services for medication regulation and diagnosis
12) Transportation
13) Supported employment
14) Family Support
15) Peer Support
16) Supervised day programs
17) Therapeutic Day Programs
18) Medical Day Programs
19) Respite

Members

Members who are enrolled in a RBHA may receive all their Behavioral Health services and medications through the RBHA. Call them directly if you have questions about your CMDP patient (see directory of RBHA's on the next page). The CMDP Behavioral Health Coordinators or the child's custodial Case Manager can help you determine the RBHA with which the patient is enrolled. The CMDP Behavioral Health Coordinators can also provide the Behavioral Health service plan information from the RBHA.

Providers

Regional Behavioral Health Authorities (RBHA's) are contracted by the Arizona Department of Health Services (ADHS). TXIX funds are paid by AHCCCS to ADHS for distribution to the RBHA's to provide covered Behavioral Health services to AHCCCS (Title XIX) and Kids Care (Title XXI) members. Calling the member service number of the appropriate RBHA can enroll an AHCCCS or Kids Care child.

RBHA	Counties Served	Member Services Telephone #
CPSA (Community Partnership of Southern Arizona)	Cochise, Greenlee, Graham, Pima, Santa Cruz	(800) 771-9889
EXCEL	LaPaz Yuma	(800) 387-4881 (800) 880-8901
NARBHA (Northern Arizona Regional Behavioral Health Authority))	Apache, Coconino, Mohave, Navajo, Yavapai	(800) 640-2123
PGBHA (Pinal Gila Behavioral Health Authority)	Gila Pinal	(800) 982-1317
ValueOptions	Maricopa	(800) 564-5465

Transportation

CMDP is responsible for transporting the member to their first appointment with the RBHA, when transportation issues exist. After the patient is enrolled in the RBHA, the RBHA becomes responsible for arranging non-emergency transportation and emergency transportation, when there is an imminent threat of harm to the child if care is not rendered expeditiously. If there are any questions about transportation for Behavioral Health services, call a CMDP Behavioral Health Coordinator.

Appeal of a Denied Referral

Outpatient Services:

If your referral for an outpatient service (e.g., psychiatric care) is denied by the RBHA, refer to the RBHA's appeal process for assistance. If you need assistance, please contact the CMDP Behavioral Health Coordinators.

Inpatient Services:

If your referral for inpatient admission is denied by the RBHA, call the CMDP Behavioral Health Coordinators or the child's custodial Case Manager. (If after hours, call the After Hours Notification Number, (800) 544-1746) CMDP Behavioral Health staff will work to resolve the issue. If the patient is non-AHCCCS (non-Title XIX), CMDP will provide Behavioral Health services until the member is eligible for AHCCCS (Title XIX).

Non-AHCCCS (Title XIX) and Non-Kids Care (Title XXI) Members

Referrals

To obtain Behavioral Health services for a non-AHCCCS (non-TXIX) child through the preferred provider network, call the CMDP Behavioral Health coordinators for assistance.

Services

The following Behavioral Health services are covered for non-AHCCCS (non-TXIX) eligible members, when prior authorized by CMDP:

- Inpatient psychiatric hospitalization, which may include inpatient psychological evaluation
- Outpatient psychiatric treatment
- Medication monitoring.

Providers

CMDP reimburses Behavioral Health professionals who deliver authorized covered services.

Appeal of a Denied Referral

If a referral for either inpatient or outpatient service is denied, contact the CMDP Behavioral Health Coordinators for further review. (If after hours, contact the After Hours Notification Number, (800) 544-1746). Additional written documentation to substantiate the referral may be requested for review. Disposition of appeals will be timely, in order to ensure that there is no negative impact on the CMDP member.

Out of State Members Non-AHCCCS (Title XIX) and Non-Kids Care (Title XXI)

Referrals:

To obtain Behavioral Health services for a child placed in foster care outside the State of Arizona, call the CMDP Behavioral Health Coordinators for assistance.

Services:

The following Behavioral Health services are covered for members placed in foster care outside the State of Arizona and must be prior authorized by CMDP:

- Inpatient psychiatric hospitalization, which may include inpatient psychological evaluation
- Outpatient psychiatric treatment
- Outpatient psychological services
- Medication monitoring

Additional services may be covered for certain members placed out of state on a case-by-case basis. The CMDP Behavioral Health Coordinator will work with the member's custodial Case Manager and the out of state courtesy Case Manager to arrange for Behavioral Health services.

Providers:

CMDP can only reimburse providers who are registered by CMDP.

Appeal of a Denied Referral:

If a referral for either inpatient or outpatient service is denied, contact the CMDP Behavioral Health Coordinators. (If after hours, contact the After Hours Notification Number (800) 544-1746). Additional written documentation to substantiate the referral may be requested for review. Disposition of appeals will be timely, in order to ensure that there is no negative impact on the CMDP member.

Claims:

See the Claims section of this Provider Manual (Chapter 7) for claims coding instructions for Behavioral Health services.

Medical Services

CRS

Children's Rehabilitative Services (CRS) is a program of the Arizona Department of Health Services, Office of Children with Special Health Care Needs. Eligibility for CRS is based on the medical illness, disability, congenital anomalies, or potentially disabling condition that has the potential for functional improvement through medical, surgical or therapeutic intervention. All CMDP members are financially eligible for CRS; however, they must be seen at a CRS clinic to determine medical eligibility.

CRS is not an acute care provider. Each CRS patient must have a PCP to provide general care and immunizations. Infectious diseases, acute trauma, and intoxications are not treated by CRS unless there is a direct relationship between these and the CRS eligible condition. The CRS Administration determines coverage through CRS.

Anyone may refer a child for CRS services. Application for services is by completion of the CRS Pediatric History and Referral Form and documentation of the child's primary diagnosis supporting the application. The child's custodial agency representative will assist in preparing the application. Whenever possible, pertinent X-ray, test results and other related medical records should accompany the referral form.

The Pediatric History and Referral Form may be photocopied and used to initiate an application for CRS. Clean copies may be requested from any of the CRS Clinics listed below:

CRS Phœnix Clinic	(602) 406-6400
CRS Flagstaff Clinic	(928) 773-2054
CRS Tucson Clinic	(520) 324-5437
CRS Yuma Clinic	(928) 344-7095

CRS provides diagnostic, surgical, hospitalization, rehabilitation, pharmacological, and allied services. CRS contracts with Arizona regional physicians who are experts in their field to treat CRS enrolled patients.

For more information about specific eligible conditions and covered services, please contact the CMDP Medical Services Department. CMDP Medical Services will assist providers in identifying CMDP members who may be eligible for CRS. Once CRS determines the child medically eligible, the child is enrolled in CRS. CRS enrolled members must receive CRS covered services through CRS providers.

Dental

CMDP covers all AHCCCS covered dental services for members. This includes preventive and restorative care. Additionally, CMDP covers orthodontia when medically necessary. The Dentist's Certificate of Medical Necessity [found at the end of this section] must be completed and signed to request orthodontic treatment.

Dentists are part of the CMDP Preferred Provider Network (PPN). Contact CMDP Provider Services to inquire about PPN dentists.

CMDP must receive complete and accurate records for reviewing services requiring prior authorization. This will assist the dental consultant, who is a State licensed dentist, in making an appropriate determination. Refer to the CMDP Dental Benefit Matrix for the list of eligible dental services and prior authorization requirements. For a determination to be made, submission of appropriate radiographs, orthodontia models (and any narrative deemed necessary) are required. Determination of prior authorization must be in writing and must be granted **before** the proposed procedure is begun. Denial of prior authorization and member non-eligibility on the date of service will result in denial of reimbursement.

* Charges are according to the AHCCCS Capped Fee-for-Service Schedule

Payment for orthodontia treatments may only be made for children who are continuing members of CMDP. Should the child leave foster care prior to the completion of orthodontic care, the child's Case Manager must identify a financially responsible person. The child's foster placement is not financially responsible for the remaining cost of services. The dentist is responsible for verifying the child's enrollment status at the time of treatment.

In order to expedite the process for prior authorization of orthodontics, a revised form has been developed. This form is required for authorization determination from the Dental Consultant and/or Medical Director. The section "*To be Completed by the Provider*" must be completed and then forwarded to the child's case manager for further information. The case manager will then return the form back to you. Once both sections are complete, return the form to CMDP along with the request for orthodontic services, diagnostic x-rays, models, photos and the "*Dentist's Certification of Medical Necessity*" form. This will expedite the process for review and for returning all documentation to you.

Please, contact our Medical Services Department for any forms or questions.

EPSDT

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, a federally mandated program, provides periodic assessment of the physical and mental development of children under twenty-one (21) years of age. The EPSDT health care screening regulations set good practice guidelines for the care of children, including all CMDP members.

EPSDT services include periodic medical screenings designed for prevention and early detection of health problems. Diagnosis and treatment are provided to children with suspected health problems or illnesses. The defined list of health care screens and procedures is indicated on the EPSDT Periodicity Schedule, included at the end of this chapter.

EPSDT providers are asked to complete the screenings listed for each period and complete the EPSDT Tracking Form appropriate to the age of the child. Additional Tracking Forms may be obtained from your CMDP Provider Services Representative or on the AHCCCS website, www.ahcccs.state.az.us. CMDP staff will review EPSDT Tracking Forms for completeness and quality identify referrals made for evaluation and treatment as well as missed opportunities for immunizations. CMDP staff may contact provider offices to schedule a record audit of EPSDT services and provide provider education about the program.

Providers are requested to notify CMDP, Member Services, when CMDP members fail to make or keep an EPSDT appointment.

EPSDT Screening Requirements

Comprehensive periodic screenings must be conducted according to the time frames identified in the periodicity schedule, and inter-periodic screenings as appropriate for each member. The periodicity schedule is based on federal mandates and is closely aligned by the Arizona Medical Association (AMA)and the American Academy of Pediatrics (AAP). The following is a summary of EPSDT Screens. Additional information may be obtained from CMDP, Medical Services.

- A comprehensive health and developmental history (including physical, nutritional and behavioral health assessments);
- A comprehensive unclothed physical examination;
- Appropriate immunizations according to age and health history;
  NOTE: The immunization schedule is included at the end of this section.
- Laboratory tests (including blood lead screening assessment appropriate to age and risk, tuberculosis screening appropriate to age and risk, anemia testing and if appropriate, diagnostic testing for sickle cell trait). The Sickle Cell Anemia Society (602) 254-5048 has educational programs to help people with sickle cell anemia.

- Health education;
- Appropriate dental screening; and
- Appropriate vision, hearing/speech testing.
- Developmental Screening. Medical Services can assist you in making referrals to the Arizona Early Intervention Program (AzEIP) or the Division of Developmental Disabilities (DDD) as needed.
- Immunizations. Providers must coordinate with the ADHS Vaccines For Children (VFC) Program in the delivery of immunization services. ADHS operates the Vaccines for Children (VFC) Program. Call (602) 230-5841 to register as a VFC provider. ADHS operates the Arizona State Immunization Information System (ASIIS). Call them at (602) 230-5894 or (877) 491-5741 to learn about the system and how to obtain the office computer program (PCImmunize) or web based program to connect your office to ASIIS.

ASIIS

All providers are required to be connected to the Arizona State Immunization Information System (ASIIS) and State Law mandates that providers report all immunizations administered to this system. **Please, instruct your staff to enter all immunization data timely and completely in order to comply with state laws and eliminate unnecessary revaccinations.**

The ASIIS system allows providers to query immunization records on individual children or groups of children. In addition, it generates reminder notices for the provider, to indicate when immunizations are due for individual children.

Please, contact ASIIS directly at (602) 230-5894 or (877) 491-5741 to obtain information on the ASIIS software program or instructions for using the web-based system. ASIIS will provide hands on training with your staff. CMDP also has the capability to access the ASIIS system to verify and obtain immunization records. If you are unable to determine a child's immunization status, please contact the EPSDT Coordinator within the Medical Services Department, at extension 7063.

We will make every effort to verify the immunization history in question.

Maternal Health/ Family Planning

Family Planning

Family planning services are covered services for CMDP members. Members aged twelve (12) and older must be notified annually of the availability of family planning services verbally by their PCP or PCO, and in writing by CMDP. Family planning services for members may receive the following medical, surgical, pharmacological and laboratory services.

- Natural family planning education, counseling, and referral to qualified health Professionals, including information on the prevention and spread of STDs.
- **STD testing, including HIV testing. This testing requires signed consent from the member's Case Manager, if the child is twelve (12) years or younger. If the child is over thirteen (13) years of age, he/she may consent to HIV testing.**
- Contraceptive counseling, medication supplies, including, but not limited to: oral and injectable contraceptives, diaphragms, condoms, foams and suppositories. Prescriptions for over-the-counter methods may be filled at CMDP pharmacies.
- Depo-Provera
- IUD is not a covered service
- Associated medical and laboratory examinations including ultrasound studies related to family planning, physical exam and pelvic exam.
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Postcoital emergency oral contraception within seventy-two (72) hours after unprotected sexual intercourse.

Prenatal Care

Due to the age of our members, pregnant CMDP adolescents are considered high risk. Pregnant members must be referred to a PCO as soon as the pregnancy is confirmed. Call CMDP Provider Services to obtain assistance in locating a PCO, (602) 351-2245 extensions 7042, 7081 or (800) 201-1795. CMDP Care Coordination staff will assist providers in coordinating care and services for the pregnant member. Call the CMDP Maternal Child Health (MCH) nurse to notify CMDP of a pregnancy and to obtain authorization to initiate prenatal care. Please instruct pregnant members to call their Case Manager or CMDP Medical Services for any assistance.
Maternity care includes medically necessary services for the care of pregnancy, treatment of pregnancy-related conditions, antepartum services and postpartum care

PLEASE NOTE: CMDP members are considered high risk, due to their age.
Consequently, the high-risk appointment standard of three (3) days, from notification of the pregnancy, must be maintained.

Pregnancy Termination

Pregnancy Termination is a covered service for CMDP members if one of the following conditions exists:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
  1. Creating a serious physical or mental health problem for the pregnant member
  2. Seriously impairing a bodily function of the pregnant member
  3. Causing dysfunction of a bodily organ or part of the pregnant member
  4. Exacerbating a health problem of the pregnant member, or
  5. Preventing the pregnant member from obtaining treatment for a health problem.

Prior Authorization (PA) is required from the CMDP Medical Director prior to performing a pregnancy termination. To obtain PA, the attending physician must complete the AHCCCS Certificate of Medical Necessity for Pregnancy Termination Form (at the end of this section—may be Xeroxed) certifying that, in the physician's professional judgment, one or more of the above criteria have been met. The completed and signed form must be faxed to CMDP Medical Services Department with a copy of an informed consent form for the termination, (signed by the CMDP member if eighteen (18) years or older).

If the member is under age 18, or is 18 years of age or older and considered an incapacitated adult, a dated signature of the member's parent or legal guardian indicating approval of the pregnancy termination procedure is required. The following documentation must accompany the AHCCCS Certificate of Medical Necessity for Pregnancy Termination Form.

- When the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities, including the name of the agency, report number and the date the report was filed.
- Signature of the legal guardian approving the termination procedure.
  Copy of the court order if someone other than the legal guardian has been given authorization to approve the termination procedure.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to CMDP within two(2) working days of the date on which the termination of pregnancy procedure was performed.

Hysterectomy

Hysterectomy or other means of sterilization is not covered unless medically necessary. Prior authorization (PA) is required. If the procedure can be substantiated as medically necessary, in addition to the supporting medical documentation, the following requirements must also be met:

- The member and legal guardian must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. Providers may use the sample AHCCCS hysterectomy consent form in this chapter.
- The provider is not required to complete a consent to sterilization form prior to performing hysterectomy procedures and the thirty (30) day waiting period required for sterilization does not apply to hysterectomy procedures.
- Unless an emergency, a second opinion may be required.
- In an emergency, PA is not required, but the physician must certify in writing that an emergency or life-threatening illness or disease exists.

Please, contact the Medical Services Department for assistance in obtaining the necessary prior authorization.

Pharmacy

CMDP's formulary encourages generic substitution whenever possible. If a brand name drug must be prescribed, documentation to support the specific drug must be submitted to CMDP Medical Services Department for prior authorization.

Specific medications do require a prior authorization. These medications include, but are not limited to:

- growth hormones
- Synagis
- Xolair
- DDAVP
- Accutane

Pharmacy coverage includes, but is not limited to:

- Legend drugs when prescribed by a physician or allied health professional within the scope of license
- Insulin, by prescription
- Insulin syringes/needles, by prescription

Over the Counter (OTC) medications may be covered on a case-by-case basis, since foster placements do not receive reimbursement for out of pocket medical expenses. Examples of covered OTC medications may include: medications, which are used for the treatment of scabies & lice, or antihistamines and decongestants, which are used for the treatment of chronic allergies. These medications must be written on a prescription and signed by the physician. A one-time authorization will be given. If the medication is ongoing, contact the Medical Services Department for prior authorization. Documentation to support medical necessity and clinical appropriateness must be submitted with the request. Examples of **non-covered OTC** items include: diapers and vitamins. Diaper costs may be reimbursed to the foster family through other funding mechanisms.

Psychotropics for limited mental health diagnoses (see Behavioral Health section in this Provider Manual) may be prescribed by a PCP. Prescriptions written by a Regional Behavioral Health Authorities' (RBHA) psychiatrist must be filled through RBHA contracted pharmacies, using the RBHA identification number. CMDP must **prior authorize** psychotropic medications in the SSRI (Selective Seratonin Reuptake Inhibitors) category of antidepressant medications.

<u>This involves only the following medications:</u>

- Prozac (Fluoxetine)
- Paxil (paroxetine)
- Zoloft
- Celexa
- Lexapro
- Luvox (fluvoxamine)
- Sarefem

Please, contact the Medical Services/Behavioral Health Department for assistance.
Scripts can be written for up to a thirty (30) day supply.

Refills

Due to the transitory nature of CMDP members, physicians may be requested to write new prescriptions for drugs before the previous supply has expired. Physicians are requested to comply with these requests, yet be aware of instances that may be an attempt to fraudulently obtain drugs. Suspected attempts to obtain drugs fraudulently must be immediately reported to CMDP, Provider Services.

Therapies (OT, PT, Speech, Audiology, Respiratory)

CMDP covers therapies that are medically necessary to improve or restore functions that have been impaired by illness or injury. CMDP Medical Services' Prior Authorization (PA) staff authorizes therapy services when medically necessary and clinically appropriate and will authorize the amount, frequency, and duration of therapy. Authorization determinations are based on the AHCCCS Medical Policy Manual. If the member is enrolled in CRS, CMDP coordinates therapy benefits with CRS.

The PCP, or specialist upon referral from the PCP, may initiate authorization for therapy by contacting CMDP Medical Services Department with a referral and physician order. A PA is not required prior to referral to the therapist for an evaluation. However, continued therapy does require PA.

For authorization to continue therapy, either the therapist or the PCP/specialist must document and submit in writing to CMDP the evaluation results and treatment plan, including goals, rehabilitation potential, location of services (home or office), length of time (from and through dates), and number of sessions. Continued authorization will require the PCP/specialist's statement of medical necessity and submission of the therapist's progress notes. The number of visits cannot exceed patient's eligibility span.

Transplants

Providers must obtain prior authorization from CMDP for all organ and tissue transplantation services. All transplant services are coordinated through the AHCCCS Office of Medical Management and the services of AHCCCS contracted transplant specialists, when available.

CMDP covers medically necessary transplantation services, and related immunosuppressant medications. Covered transplants must be non-experimental and non-investigational for the specific organ/tissue and specific medical condition. Solid organ transplantation services must be provided in a Centers for Medicare and Medicaid Services (CMS) certified and United Network for Organ Sharing (UNOS) approved transplant center that is contracted with AHCCCS, unless otherwise approved by the CMDP Medical Director, and/or the AHCCCS Chief Medical Officer or designee. Bone marrow transplantation services should be provided in a facility which has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation as a bone marrow transplant center that is contracted with AHCCCS, unless otherwise approved by the CMDP Medical Director and/or AHCCCS Chief Medical Officer or designee.

Questions regarding coverage and procedures for transplants should be immediately directed to the CMDP Medical Services Department (602) 351-2245 or (800) 201-1795.

Hospital Utilization

CMDP's inpatient hospital services refer to those medically necessary services provided by, or under the direction of, a primary care physician, practitioner or a specialty physician on referral from a primary care physician, which are ordinarily furnished in a hospital.

Concurrent Review is performed on admission and at frequent intervals during inpatient hospital stays. Reviews assess the appropriate usage of ancillary resources, levels of care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for continued stay and evaluates quality of care. Discharge Planning begins upon admission.

Concurrent review is initiated within one (1) business day of notification and continues at intervals appropriate to patient condition, based on the review findings. During review, the following are considered:

- Necessity of admission and appropriateness of service setting
- Quality of care
- Length of stay
- Discharge needs, and
- Utilization pattern analysis.

The Medical Services Department, in coordination with the Medical Director, determines the appropriateness of continued services, in consultation with physician advisors, as necessary.

Continued hospital services may be denied when:

- A member no longer meets intensity and severity criteria
- A member is not making progress in a rehabilitative program, or
- A member can be transferred safely to a lower LOC.

Please, contact the Concurrent Review Nurse, within the Medical Services Department, with any inpatient concerns.

The hospital must notify CMDP's Medical Services Department within twenty-four (24) hours of admission.

Transportation

Emergency Transportation

Emergency transport by ground or air ambulance to the nearest clinically appropriate hospital or emergency department is covered if medically necessary based on the member's medical condition at time of transport, and if no other transport is appropriate and available. The ambulance provider must notify CMDP within 10 days of the transport or the claim may be denied.

Non-emergency/Medically Necessary

Transportation to medical providers, including a pharmacy to pick up or order prescription drugs or medical supplies, may be provided by CMDP for a member or foster placement that is unable to arrange for transportation. * To request non-emergency transportation for medical necessity, contact CMDP Member Services and be prepared to discuss the destination and reason for the transport. CMDP requires that a responsible adult accompany minors; CMDP cannot reimburse the adult (except when the medical provider is outside the member's service area – see below).

*Note: Foster caregivers provide transportation to routine medical appointments for children for whom they receive monthly maintenance payments from DES. Foster caregivers under contract, such as shelters and group care agencies, typically have contractual responsibilities regarding the provision of transportation for routine medical care. In certain extenuating circumstances, when a paid foster care provider is unable to make transportation arrangements, the above provision applies. Some foster caregivers, such as unlicensed relatives, do not receive maintenance payments from DES. Transportation assistance as described is available to members in such placements.

Medically Necessary Transportation Outside the Member's Service Area

For services that are only available outside the member's service area (generally the county), transportation may be reimbursed by CMDP (where other state or federally funded reimbursement is not provided). ** Additionally, meals and lodging may be reimbursed [at the State employee per diem rate] for the member and one attendant during the travel time required to the medical provider and again upon return home. Services of an attendant [responsible adult] may be reimbursed at no more than the federal minimum wage.

**Note: Generally, the transportation needs of a child are taken into account in determining the rate of foster care maintenance payment made to a foster caregiver by DES. In situations where the foster caregiver does not otherwise receive reimbursement for additional transportation needs, or for unpaid foster caregivers, such as unlicensed relatives, or where extenuating circumstances exist, transportation assistance as described is available.

Ambulance Transfer between medical providers

Transfer by ambulance between medical providers, i.e., between treating hospitals or hospital to nursing facility, when prior authorized by CMDP, is covered. The hospital requesting the transfer must contact CMDP's Concurrent Review Nurse to coordinate the transportation.

At a minimum, Hospital to Hospital or Hospital to Specialty only transportation should be reimbursed at the Basic Life Support Rate. If the member's medical conditions requires, this could also be reimbursed at advances Life Support rate.

Transportation to Behavioral Health Providers

Transportation to behavioral health providers is the responsibility of the Regional Behavioral Health Authorities (RBHA) for members enrolled in the RBHA. CMDP is responsible for transporting the member to their first appointment with the RBHA, if necessary. If there is any question about responsibility for transportation to behavioral health providers, contact a CMDP Behavioral Health Specialist.

Vision

CMDP covers vision care including refractions, eyeglasses, and care of medical conditions of the eye. Appointments for refractions do not require prior authorization (PA). Eyeglasses meeting the conditions set forth in the CMDP PA Guidelines, do not require PA. Repair and replacement of eyeglasses are covered.

Contact lenses are only covered when needed post cataract surgery or when determined medically necessary. Prescriptions for contact lenses require prior authorization and must state why they are medically necessary instead of glasses.

Initial referral to an ophthalmologist does not require PA. Ongoing treatment does require authorization.

Vision Therapy is not a covered service: based on publication by the American Academy of Pediatrics (AAP) and The American Academy of Ophthalmologist (AAO). No scientific evidence exists for the efficacy of eye exercises (vision therapy) or the use of special tinted lenses.

Out-of-State Services

For foster children residing outside of Arizona, CMDP is responsible to reimburse:

- Any medically necessary services not covered by the receiving State's Medicaid program.

CHAPTER APPENDIX

Exhibit 430-1 Arizona Health Care Cost Containment System (AHCCCS) Periodicity Schedules

- EPSDT Periodicity Schedule
- Dental Periodicity Schedule
- Vision Periodicity Schedule
- Hearing and Speech Periodicity Schedule

Exhibit 430-2 AHCCCS Immunization Schedules

Recommended Childhood Immunization Schedule, US,

- January–June 2004
- July-December 2004
- Children and Adolescents who start late or who are > One Month Behind

Exhibit 410-1 AHCCCS Certificate of Necessity for Pregnancy Termination

CMD-1006A DES/CMDP Dentist's Certification of Medical Necessity

CMD-013 DES/CMDP Physician's Certification of Medical Necessity

CMD-1017AFORNA DES/CMDP Statement of Responsibility for Orthodontic Treatment

CMD-078 DES/CMDP CMDP Family Planning Services

Chapter 6

UTILIZATION AND QUALITY MANAGEMENT (UM/QM)

Utilization Management (UM)

CMDP uses several mechanisms to manage service utilization.

Preferred Provider Network (PPN)

CMDP recruits with PCPs and select specialty physicians statewide. These providers agree to provide quality medical care to CMDP members, striving to reduce duplication of services to children and working within the regulations governing service delivery to wards of the State.

Prior Authorization

Prior Authorization (PA) is the act of providing notice to CMDP of a requested service prior to its delivery. CMDP's PA requirements help to ensure that PPN providers are used when appropriate and available, that regulations governing service delivery to CMDP members are followed, and that care and services are coordinated and communicated to those involved. Prior Authorization nurses use InterQual criteria, AHCCCS and CMDP policy, and state regulations to guide service authorizations. Inpatient certification days are based on the PAS Western Regional 50th percentile.

PA is generally via FAX to CMDP. If the patient is an eligible member and meets medical necessity criteria, a PA# will be given to your office. The service requested must be a covered service and the provider must be AHCCCS registered. The PA number should be used on the claim, resulting from the authorized service, to ensure prompt payment. If additional documentation is needed to determine service authorization, the provider will be asked to fax the required document(s) to CMDP. If you desire to conduct prior authorization, electronically, please contact CMDP to become a trading partner. Contact information and testing schedules can be obtained at www.de.state.az.us/hipaa.

Elective Admissions

Elective hospital admissions require PA. All laboratory and x-ray procedures required for elective inpatient or outpatient surgery shall be done on an outpatient basis within seventy-two (72) hours prior to the scheduled surgery.

Emergency Services

Emergency services do not require PA; however, they do require notification to CMDP [telephone: (800) 544-1746 or fax (602) 351-8529] within these identified time lines:

- Emergency department visit-within twelve (12) hours of service delivery
- Emergency admission-within twenty-four (24) hours of admission
- Ambulance transportation-within ten (10) days of transport

Concurrent Review

CMDP staff conducts concurrent review weekdays between 8:00 am and 5:00 pm. Concurrent review of hospitalized members generally occurs telephonically on a daily basis between the CMDP Concurrent Review Nurse (CRN) and the utilization management/discharge planning staff of the inpatient facility. The CRN may make an on-site visit, as determined necessary, based on the member's hospital stay.

Medical Services' nurses use the PAS Western Regional 50th percentile and InterQual IS [intensity of service] and SI [severity of illness] criteria, AHCCCS and CMDP policy, and state regulations to guide service delivery decisions.

When the CRN determines that continued stay is no longer medically necessary, the case will be reviewed with the attending physician and the member's Case Manager. The attending physician may contact the CMDP Medical Director at any time to justify a medically necessary continued stay. The Medical Director may involve a peer reviewer as needed.

Discharge Planning

The CMDP CRN also coordinates discharge planning (see above under Concurrent Review). Medical Services staff uses InterQual standards, AHCCCS and CMDP policy, and state regulations to guide service delivery decisions. Discharge planning begins upon admission.

Care Coordination

CMDP nurses and social workers provide care coordination for all pregnant teens and for children at medical risk. If you have a CMDP member who would benefit from this care coordination, please contact the Medical Services Department and ask to speak to the Care Coordinator.

"EMERGENCY MEDICAL CONDITION" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Medical Director Review

The CMDP Medical Director is involved in all cases when Medical Services staff questions the appropriateness of care, or when services do not or no longer meet medical necessity for authorization or certification criteria. Only the Medical Director can deny, reduce, suspend, or terminate services. Any provider delivering care to a CMDP member may contact the Medical Director by calling CMDP's Medical Services Department. The Medical Director and CMDP staff also works with a contracted dental consultant from the Department of Health Services/Office of Oral Health and a behavioral health consultant. The CMDP Dental Consultant assists to identify high quality, cost-effective, and appropriate services for CMDP members.

Retrospective Claims Review

Claims are selected for retrospective review according to written criteria. A nurse, and/or the Medical Director review criteria reflecting high cost, questionable billing practices, or excessive utilization. CMDP may recoup money inappropriately paid, after notice to the provider involved. The provider has the opportunity to appeal CMDP's recoupment decision.

Provider Education

CMDP may prepare quarterly provider profiles, based on claims data, comparing individual provider utilization for selected categories of service (i.e., number of specialty referrals, inpatient admissions, non-generic scripts) to the statewide average. The purpose of this provider profiling is to provide feedback to providers about their practice patterns related to services delivered to CMDP members. If services provided are contrary to CMDP standards compared to other physicians of the same specialty, the Medical Director may discuss this with the provider to determine alternatives.

CMDP also distributes a quarterly Provider Newsletter to update providers about CMDP procedures and helpful tips.

Quality Management (QM)

QM Committee

CMDP maintains a Quality Management Committee. The Committee is chaired by the Medical Director and meets quarterly to approve medical policy and set the agenda for clinical studies and quality improvement activities. If you would like to join CMDP's Quality Management Committee, please contact the Medical Director, or the Manager of Medical Services at ext. 7070. Annually, CMDP evaluates its Quality Management Program to determine its effectiveness and select quality improvement studies for the upcoming year.

Customer Satisfaction

As part of Quality Management, CMDP conducts periodic member and provider satisfaction surveys. Results are used to address areas where improvement is needed.

Medical Record Audits

CMDP Medical Services' nurses periodically conduct medical record and EPSDT audits in compliance with the standards found in the AHCCCS Medical Policy Manual [the audit tool is at the end of this chapter]. This may offer opportunities to educate providers and their office staff about CMDP policies and standards.

CHAPTER APPENDIX

CMDP Medical Record Audit Tool

Chapter 7

CMDP CLAIMS

Introduction to the CMDP Claims Unit

The CMDP Claims Unit processes claims submitted by providers to CMDP.

This section explains:

- How claims must be submitted (forms, codes, documentation required, timely filing).
- How claims are adjudicated and paid.
- How to read the remittance advice.
- How to resubmit a claim.
- How to request reconsideration of a processed claim.
- How to query CMDP regarding the status of your claim.

This section also includes:

- CMDP claims policy.
- Special codes used to submit claims for EPSDT, Therapy, and Behavioral Health services.
- Sample completed claim forms.
- Tips on avoiding common billing errors.

Claim Forms

Specific types of claim forms are required for reporting different types of health care services.

- Medical services are filed on the standard CMS 1500 claim form. Medical services include services provided by physicians, laboratory and radiology facilities, durable medical equipment providers, infusion and home health providers, and other practitioners.

- Inpatient, outpatient, and emergency room facility claims are filed on a standard UB-92 claim form.

- Dental claims are filed on the ADA 2002 universal form.

All claims submitted on hard copy should be original copies and must be legible and suitable for microfilming for permanent record retention. Illegible or poor quality claims will be returned unprocessed. Claims may not be submitted via facsimile machine (fax). In addition, claims will be denied (unaccepted) if required documentation is missing. In preparing the claim form, please leave the upper middle and right side of the claim form blank for use in numbering of the claim. This area is the blank space immediately above the solid blank line and contains the words "HEALTH INSURANCE CLAIM FORM."

Electronic Claims Submission

If you desire to submit claims electronically, please contact CMDP to become a trading partner. Contact information and testing schedules can be obtained at www.de.state.az.us/hipaa.

Coding Used

The CMDP computerized claims processing system recognizes the AHCCCS mandated codes. These include; Current Procedural Terminology, (CPT Expert); International Classification of Diseases, 9th Revision (ICD-9); HCFA Common Procedure Coding System (HCPCS); and the American Dental Association's (ADA) Current Dental Terminology, Forth Edition (CDT-4).

- CPT - reporting medical services and procedures performed by physicians.
- ICD-9-CM- reporting diagnoses/conditions.
- HCPCS - reporting non-physician procedures, such as ambulance services, durable medical equipment and specific supplies.
- ADA - reporting of dental procedures.
- Immunizations covered under the Vaccines for Children (VFC) Program:

90633	90669	90720
90634	90698	90721
90645	90700	90723
90646	90701	90732
90647	90702	90740
90648	90707	90743
90655	90713	90744
90657	90716	90747
90658	90718	90748

Providers must not use immunization administration CPT codes 90471 and 90472, 90473 & 90474 when billing for vaccines under the federal Vaccines for Children (VFC) Program.

Members Identification Number

This unique identifying number is assigned by CMDP and may be found on the member ID card.

Provider Identification Number

The Provider identification number is the same as the AHCCCS Provider Registration Number. All CMDP Providers, including out of state, must be AHCCCS Registration.

Submission Address

Claims should be submitted to:

DES/CMDP
Site Code 942C
P.O. Box 29202
Phoenix, Arizona
85038-9202

Documentation required to pay claims

The CMS 1500 claim form requires the following documentation as applicable:

- EPSDT Form
- Ambulance trip report

The UB-92 claim form requires the following **inpatient** documentation for **medical review**:

- Admission sheet (Facesheet)
- Admission history and physical
- Discharge summary or an interim summary, if claim is split
- Operative reports
- Labor and delivery report
- Emergency record, if admission was through the emergency room
- Observation progress notes & physician orders
- Itemized statement
- Inpatient progress notes for acute and critical care

Dentist may be requested to submit the following documentation:

- Narrative for unauthorized procedures requiring authorization
- X-rays for pretreats and retro-review claims

Claims Filing Time Limits

Providers are encouraged to bill for services as soon as possible after the services have been provided. Claims must be initially filed within six (6) months from the date of service. A **"clean claim"*** must be filed within twelve (12) months of the date of service. CMDP will adjudicate "clean claims" within 30 to 45 days of receipt.

Claims lacking information necessary for entry into our data processing system will be denied, a remittance advice will be mailed explaining reason of denial. When resubmitting your claim with the corrected information, include a copy of the remittance advice as proof of prior submission. CMDP will honor the received date of the original claim as long as all other timely filing criteria are met. (See section on resubmission on Page 7-12).

***A "clean claim" is defined as a claim that includes all necessary documentation for adjudication and for which the initial submission is received within six (6) months from the date of service.**

Adjudication

When adjudicating claims, the system confirms that a provider ID, recipient ID, date(s) of service, diagnosis codes, procedure/revenue codes, and billed charges are present on the claim. These data elements, as applicable, are required on all claims.

After editing for completeness and correctness of the data submitted, the system reviews the data to ensure that data fields are valid and logical. The system edits ensure that:

- Member is on file, eligible and entitled to the service. If a provider has questions about a child's eligibility, he/she should contact the CMDP Member Service Unit.
- Valid AHCCCS/CMDP provider ID number.
- The Provider is currently registered with CMDP and the registration allows billing for claimed service. If a provider has questions about his/her CMDP registration, he/she should contact the Provider Services (602) 351-2245 or (800) 201-1795.
- The service was covered by CMDP on the date(s) it was delivered
- Diagnosis and procedure(s) are valid for the date(s) of service
- The UB-92 tier hierarchy for processing claims is applied.

Another set of edits assures that the claim complies with CMDP policy requirements. These include:

- Prior Authorization (PA) is obtained if required
- The service is allowed for the recipient's age and gender
- The claim is reviewed by CMDP medical staff before payment, if required

The final step in the review of the claim is an audit process to assure that reimbursement for the service has not been previously paid or does not exceed service limitations. The claims system audits for duplicates where the recipient, provider, dates of service, and procedure/diagnosis are the same on a paid claim and the claim being reviewed.

Payment (Fee Schedule Information)

CMDP pays according to AHCCCS Fee-For-Service fees. "By Report" fees are established according to usual and customary rates. Providers desiring a copy of the CMDP/AHCCCS fee schedule pertaining to their medical specialty may request the applicable section(s) by calling (602) 351-2245, extension 7042, or (800) 201-1795. This information can also be found on the AHCCCS website www.ahcccs.state.az.us.com, or in writing to:

Provider Services, Site Code 942C
Comprehensive Medical and Dental Program
P.O. Box 29202
Phoenix, Arizona 85038-9202

Billing for Services

Medical services billed on the CMS 1500 are reimbursed at the contract rate or the lesser of the CMDP/AHCCCS capped fee or billed charges in the absence of a contracted rate.

Inpatient hospital services billed on the UB-92 are reimbursed at the facility's tiered per diem rate. The tiered per diem system consists of the following service tiers: Maternity, NICU, ICU, Surgery, Psychiatric, Nursery and Routine. An inpatient claim may split across no more than two tier levels.

CMDP reimburses in state non-IHS hospitals for outpatient services billed on the UB-92 claim form. Covered charges are multiplied by the hospital-specific outpatient cost-to-charge ratio.

Quick pay discounts and slow pay penalties are applied to in-state, non-IHS general acute hospital outpatient UB-92 claims according to AHCCCS/CMDP policy.

If none of the above pricing methodologies have been applied at this point, the claim is manually priced, generally at 65 % of covered billed charges.

Please be sure to include your federal taxpayer I.D. number on all claims.

An AHCCCS Provider Identification Number (PIN) must be included in section 33 on CMS 1500 claim forms.

Remittance Advice

For an explanation of fields found on remit and a review of pay, pend, and deny codes, see sample at the end of Chapter 7.

Resubmission

Providers will be informed through remittance advice form when a claim is not a clean claim or is denied. Claims are denied when complete and accurate information necessary to process the claim has not been provided. Providers may resubmit any claim returned unprocessed or denied using the following procedures:

CMS 1500

- Submit an entire **new claim** to CMDP.
- Stamp or write on the top of the new claim **"Resubmission"**
- Attach a copy of the remittance advice that indicates the original denial reason.
- Attach all required documentation to verify a clean claim. This includes the documentation originally submitted and any additional documentation requested by CMDP.

Dental Claims (ADA2002)

Use one of the following methods to resubmit denial dental claims.

- Providers should make the necessary corrections to the ORIGINAL claim form, and attach any necessary documentation and a copy of the remittance advice when resubmitting the dental claim.
- If necessary, attach documentation that explains the reason you believe the original claim was incorrectly denied.

Claims Status Queries

The CMDP Claims Unit can identify payment status of your claim. Staff is available by phone Monday thru Friday from 8:00am to 5:00 pm by calling (602) 351-2245 ext 7000 or 7001. The Provider Service staff can also answer questions regarding pended or denied claims. Staff is available at (602) 351-2245, (800) 201-1795. Please have available:

- Name/ID# of CMDP member
- Name/ID# of CMDP provider
- Date of service
- Claims Reference Number (CRN)

Fraud and Abuse

Claims are examined for the sequencing and timing of a member's particular claims to determine if the claims are consistent with sound medical practice. If discrepancies are identified, a provider may be referred to the Fraud and Abuse Unit or Quality Management for further investigation.

Claims Disputes

Provider may request review of a claim denial or adjudication for reconsideration with a cover letter containing the reasons for review. Enclose a new claim, with all supporting documentation with copy of remittance advice for claim being disputed. Mail your request to:

Arizona Department of Economic Security
CMDP-942C
Attn: Grievance Coordinator
P.O. BOX 29202
Phoenix, AZ 85038-9202

Providers have 12 months from the date of service to either appeal the processing of the claim or to file a formal grievance. Please see Chapter 8 for instructions on the grievance procedures. A request for review of a claim does not constitute a grievance.

CMDP Claims Policy

The following CMDP policies affect claims processing. You may request a copy of any of these CMDP policies by calling the Provider Service Department.

Missed Appointments

CMDP does not pay for missed appointments. Foster caregivers are requested to notify providers in advance when a foster child is unable to keep an appointment. Please inform CMDP Provider Services if a foster child repeatedly fails to appear for appointments. CMDP will make every effort to rectify the problem.

Medical Claims Review

Prior to adjudicating, the office of the Medical Director will review the following types of claims:

- Any complex surgical procedure
- A appropriate level of service
- UB-92 claim identified as an outlier
- Claim for ICU services

If all of the information is accurate and accepted by the Medical Director, the claim is identified as a **"clean claim"** and payment can be processed. Review by the Medical Director "stops the clock" counting the 30 day claims processing time.

Prior Authorization Required for**:**

See PA section of this Manual for further discussion of CMDP/PA requirements.

- All rentals of Durable Medical Equipment
- Medically necessary transportation
- Specialty treatment referrals
- Therapy treatment services (PT, OT, Speech)
- Diagnostic testing: MRI, BAER, EEG, EMG, CT scan, EKG (echocardiogram) dialysis etc.
- Surgeons must obtain separate PA from that of hospital
- Ambulatory surgery centers need separate PA from physicians
- All inpatient hospital stays
- All Behavioral Health Services
- All orthodontia

CMDP Claims Policy, continued

Out of state coverage

A member who is temporarily out of the state is entitled to receive benefits under any of the following conditions:

- Medical services are required because of a medical emergency.
- The member requires a particular treatment that can only be obtained in another state.
- The member has a chronic illness necessitating treatment during a temporary absence from the state or the condition must be stabilized before returning to the state.

Filing Tips for Timely Filing

Provider will receive more accurate and timely claims payment if these guidelines are as followed:

- Do not bill for routine office supplies such as cotton swabs, bandages, syringes, etc. These are considered "stock" supplies normally included in the office fee and are not reimbursed separately. Non-routine supplies must be billed with the appropriate HCPCS code.
- Bill anesthesia claims with the appropriate American Society of Anesthesiologists (ASA) code and the number of time units expressed in fifteen-minute increments.
- Submit separate claim for each member.
- Submit a separate claim for each provider.
- Use your CMDP provider ID number (PIN#).
- Ensure claims are legible.
- Include an Explanation of Benefits from other insurance, if applicable.
- Do not fax copies, these are not considered an original document for processing.

Claims Submission Instructions

CMS 1500

The following table outlines information that must be provided on the CMS 1500 claim form. The boxes listed in the table correspond to the boxes on the CMS 1500 form. A sample CMS 1500 form is also included.

CMS 1500 Box Number	Information Required
1	Program Block
1a	Member's CMDP I.D. Number (may be obtained from the member roster or member identification card)
2	Member name
3	Member date of birth
5	Member address NOT required
9	Other Insured's Name
9a	Other Insured's Policy or Group Number
9b	Other Insured's Date of Birth and Sex
9c	Employer's Name or School Name
9d	Insurance Plan Name or Program Name
10	Is Patient's Condition Related to: Check appropriate box
11	Insured's Group Policy or FECA Number
11a	Insured's Date of Birth or Sex
11c	Insurance Plan Name or Program Name
11d	Is There Another Health Benefit Plan
14	Date of Illness or Injury
17	Name of Referring Physician
18	Admission and discharge dates if services are related to a hospitalization
20	Identify if lab work was sent out. Laboratory must be CLIA certified or waived
21	ICD diagnosis numeric (in full with leading 0 and decimal as appropriate). Narrative may be included
22	Medicaid Resubmission Code (Resubmissions or Adjustments enter "A"/ Voids "V"
23	Prior authorization number, if applicable. If prior authorization is required for the service, failure to include this number may result in denial reimbursement, or delays in processing
24A	Date(s) of service
24B	Place(s) of service (e.g. office, in-hospital, etc.)
24D	CPT procedure code with any appropriate modifier. If CPT procedure code does not apply, HCPCS codes may be used including any alpha characters and/or modifiers
24E	Diagnosis
24F	Billed charges
24G	Number of services billed (e.g. days, units, etc.)
24H	Identify if services performed under EPSDT program (see Chapter __ and the EPSDT Reference Guide for information on EPSDT qualifying services)
24I	Emergency

24J	COB (Coordination of Benefits)
25	Federal tax identification number
26	Patient account number
28	Total of all charges billed
31	Signature of physician or provider of service
32	Facility name where the services were provided (e.g., name of hospital for inpatient services, independent laboratory, etc.)
33	Provider's pay to address, CMDP Provider Identification Number (PIN)

See Chapter Appendix for a completed sample of required fields for the CMS 1500 claim form.

Place of Service

Enter the two-digit code that describes the place of service.

11 Office	51 Inpatient Psych Facility
12 Patient's Residence	52 Psych Facility Partial Hospitalization
21 Inpatient Hospital	53 Community Mental Health Center
22 Outpatient Hospital	54 ICF/Mentally Retarded (ICF/MR)
23 ER – Hospital	55 Residential Substance Abuse Treatment Facility
24 ASC	56 Psych Residential Treatment Center (RTC)
25 Birthing Center	61 Comprehensive Inpatient Rehabilitation Facility
26 Military Treatment Facility	62 Comprehensive Outpatient Rehabilitation Facility
31 Skilled Nursing Facility	65 ESRD Treatment Facility
32 Nursing	71 State or Local Public Health Clinic
33 Custodial Care Facility	72 Rural Health Clinic
34 Hospice	81 Independent Laboratory
41 Ambulance – Land	99 Other Unlisted Facility
42 Ambulance - Air or Water	

Category of Service

COS Code	COS Description
01	Medicine
02	Surgery
03	Respiratory Therapy
05	Occupational Therapy
06	Physical Therapy
07	Speech/Hearing Therapy
08	EPSDT
09	Pharmacy
10	Inpatient Hospital (Room & Board and ancillary)
11	Dental
12	Pathology & Laboratory
13	Radiology
14	Emergency Transportation
15	DME and Appliances
16	Out-Patient Facility Fees
17	ICF
18	SNF
19	ICF/MR
20	Hospice Inpatient Care
21	Hospice Home Care
22	Home Delivered Meals
23	Homemaker Service
24	Adult Day Health Service
26	Respite Care Services
27	IHS Outpatient Services
28	Attendant Care
29	Home Health Aid Service
30	Home Health Nurse Service
31	Non-Emergency Transportation
32	Habilitation
37	Chiropractic Services
39	Personal Care Services
40	Medical Supplies
42	DD Programs (DD Day Care Programs)
44	Home & Community Based Services (other) (HCBS)
45	Rehabilitation
46	Environmental
47	Mental Health Services
48	Licensed Midwife
98	Case Manager

Procedure Modifiers

Not all modifiers are valid for every procedure code and date of service combination.

Procedure Modifier	Modifier Description
AR	Return Ambulance Trip
FP	Family Planning Services
LL	Lease/Rental
LT	Identifies Left Side Body Procedures
NR	New When Rented
NU	New Equipment
RP	Replacement and Repair
RR	Rental/DME
RT	Identifies Right Side Body Procedures
TC	Technical Component
SL	Vaccine Administration - Children Age 0 - 18
2X	Second transport of single recipient by same provider on one date of service
21	Prolonged Evaluation and Management Services
22	Unusual Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation & Management Services
25	Significant, Separate Ident E&M , Same Md & Day
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
50	Bilateral Procedure (Pay 50%)
51	Multiple Procedure
52	Reduced Services
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged/Rental Procedure or Service by Same Physician During Post-op Period
59	Distinct Procedural Services
62	Two Surgeons/Different Skills
63	Procedure performed on infants
66	Surgical Team
75	Concurrent Care
76	Repeat Procedure/Same Physician
77	Repeat Procedure/Another Physician
78	Return to OR for Related Procedure Post-Op
79	Unrelated Procedure/Service, Same Medical Doctor Post-op
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Non-emergency Transportation 911 Calls
99	Multiple Modifiers

E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit

Dental Claims Procedures

The service provider completes the ADA 2002 Form. All dental claims submitted to CMDP must include the following data:

	Information Required
1	Type of Transaction (Check all applicable boxes)
2	Predetermination/Preauthorization Number
3	Primary Payer Information Name, Address, City, State, and Zip Code
4	Other Dental or Medical Coverage? Check appropriate box
5	Subscriber Name
6	Date of Birth
7	Gender
8	Subscriber ID # (SSN or ID #)
9	Plan/Group Number
10	Relation to Primary Subscriber (Check appropriate box)
11	Other Carrier information
12	Primary Subscriber Name and Address
13	Date of Birth
14	Gender
15	Subscriber ID #
16	Plan/Group Number
17	Employer Name
18	Patient's relationship to primary subscriber (Check appropriate box)
19	Student status, if applicable
20	Patient Name and Address
21	Patient date of birth
22	Gender
23	Patient ID number
24	Procedure Date
25	Area of Oral Cavity
26	Tooth System
27	Tooth Identifier (Number or Letter)
28	Tooth Surface
29	Procedure Code
30	Description
31	Fee
32	Other Fees
33	Total Fees
34	Missing teeth inventory
35	Remarks for unusual services
36	Authorizations
37	Authorizations
38	Place of Treatment
39	Radiographs or models enclosed?
40	Is treatment for orthodontics?

	Information Required
41	Date of Appliance
42	# of Months remaining for treatment completion
43	Prosthesis Replacement
44	Date of prior Prosthesis Replacement
45	3rd Party Liability
46	Date of Accident, if applicable
47	State of Accident, if applicable
48	Group/Provider Name, Address, City, State, and Zip Code
49	Group/Provider ID #
50	Group/Dentist's License Number
51	Group/Dentist's Social Security number or T.I.N.
52	Group/Dentist's Phone Number
53	Treating Provider Signature (if claim manually prepared)
54	Treating Provider ID #
55	Treating Dentist's License Number
56	Treating Provider Name, Address, City, State, and Zip Code
57	Treating Dentist's Phone Number
58	Treating Provider Specialty

See CMDP-Approved ADA2002 Claim Form for sample of fields required for a dental claim to be considered acceptable.

Orthodontia Payments will be processed according to the CMDP Prior Authorized schedule of periodic payments.

Hospital Claims Procedures

The service provider completes a UB-92 claim form, with required attachments.

All hospital claims submitted to CMDP must include:

UB-92 Box Number	Information Required
1	Provider data. Enter the name, address and phone number of the provider rendering service
3	Patient Control No.
4	Bill Type
5	Fed. Tax No.
6	Statement Covered Period
7	Covered Days
12	Patient Name
14	Patient Birth Date
15	Sex
16	Marital Status
17	Admission Date
18	Admission Hour
19	Admit Type
20	Admit Source
21	Discharge Hour
22	Patient Status
41	Value Codes and Amounts - Required if Applicable
42	Revenue Code
43	Revenue Code Description
44	HCPCS/Rates
46	Service Units
47	Total Charges by Revenue Code
48	Non-covered Charges
50	(A-C) Payer - The CMDP claim should be submitted with the carrier's explanation of benefits (EOB)
51	(A-C) Provider No.
54	(A-C) Prior Payments - Required if Applicable
58	(A-C) Insured's Name
60	(A-C) Patient identification number
63	(A-C) Treatment Authorization - if Applicable
67	Principal Diagnosis
68-75	Other Diagnosis - Required if Applicable
76	Admitting Diagnosis - Required if Applicable
77	E-Codes - Required if Applicable
80	Principal Procedure Code and Dates - Required if Applicable
82	Attending Physician
84	Remarks - Required if Applicable
85	Provider signature (if claim manually prepared)
86	Date

Hierarchy for Processing UB Claims

Tier	Identification Criteria	Allowed Splits
MATERNITY	A primary diagnosis defined as maternity **640.XX - 643.XX, 644.2X - 676.XX, V22.XX - V24.XX or V24.xx.**	None
NICU	Revenue Code = 174 (175 before 9/1/96) **AND** the provider has a level II or III NICU	Nursery
ICU	Revenue code **equal** to **200 - 204, 207-212, or 219.**	Surgery Psychiatric Routine
SURGERY	Surgery is identified by a revenue code of **36X.** To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list. The Surgery tier can only split with the ICU tier. All claim accommodation days that do not qualify at the ICU tier will be classified at the Surgery tier.	ICU
PSYCHIATRIC	Psychiatric Revenue Codes - **114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx - 316.xx**. If a routine revenue code is present and all diagnoses codes on the claim are equal to **290.XX - 316.XX**, classify as a psychiatric claim.	ICU
NURSERY	Revenue Codes of **17X (excluding 174)**	NICU
ROUTINE	Revenue Codes of **100 - 101, 110 - 113, 116 - 123, 126 - 133, 136 - 143, 146 - 153, 156 - 159, 16X, 206, 216, or 214.**	ICU

Nursing Facility Services

CMDP only pays for the date of admission up to, but not including, the date of discharge, unless the patient expires.
Long term care facilities must bill for room and board services on the UB-92 claim form. The table below summarizes the allowable revenue codes and bill types, effective with dates of service on and after October 1, 2003.

Revenue Codes		Allowable Bill Types
190	Subacute General	86X
191	Subacute Care Level I	110-179, 211-228, 611-628
192	Subacute Care Level II	110-179, 211-228, 611-628
193	Subacute Care Level III	110-179, 211-228, 611-628
183	LOA – Therapeutic (For home visit by recipient	211-228, 611-628
185	LOA – Bed Hold (For short-term Hospitalization)	211-228, 611-628

When billing revenue codes 183 and 185, providers must split bill and submit claims on separate UB-92 claim forms using the appropriate bill types and patient status codes.

Billing CPT/HCPCS Codes with Revenue Codes

UB-92 Hospital Billing Requirements for Rehabilitative Services	
Physical Therapy	Acute Care Recipients Under 21 • Covered in outpatient setting • PA *not* Required
Revenue Code	**CPT/HCPCS Codes**
420 Physical Therapy	Revenue code not allowed for fee-for-service billing
421 PT/Visit	97010-97140, 97504-97546, 97601, 97602, 97799
422 PT/Hourly	Not Allowed
423 PT/Group	97150
424 PT/Evaluation	97001, 97002, 97703, 97750, Q0086
429 Other PT	97010-97750, 97799
Occupational Therapy	Acute Care Recipients Under 21 • Covered in outpatient setting • PA *not* required
Revenue Code	**CPT/HCPCS Codes**
430 OT	Revenue code not allowed for fee-for-service
431 OT/Visit	97504-97546, 97799
432 OT/Hour	Not Allowed
434 OT/Evaluation	97003, 97004, 97750
439 Other OT	97504-97546, 97799
Speech Therapy	Acute Care Recipients Under 21 • Covered in outpatient setting • PA *no*t required
Revenue Code	**CPT/HCPCS Codes**
440 Speech Pathology	Revenue code not allowed for fee-for-service billing
441 Speech/Visit	92507
442 Speech/Hour	Revenue code not allowed for fee-for-service billing
443 Speech/Group	92508
444 Speech/Evaluation	92506, 92610, 92611
449 Other Speech	92506, 92507, 92526

Observation Services

Observation Services are those reasonable services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met.

A physician or another individual authorized to admit patients to the hospital, or to order outpatient diagnostic tests, or treatments, must provide a written order of observation services.

In general, observation status should not exceed 24 hours. This time limit may be exceeded if medically necessary, to evaluate the medical condition and/or treatment of a recipient. Exceptions to the 24-hour limit must be prior authorized.

Observation services that directly precede an inpatient admission to the same hospital must not be billed separately. These charges must be billed on the inpatient claim. The inpatient claim is priced at the tiered per diem rate based on the number of allowed accommodation days. Reimbursement for the observation services provided before the hospital admission is included in the tiered per diem payment.

Medical review for continued observation status will consider each case on an individual basis.

Ambulatory Surgery Centers

Ambulatory Surgery Centers (ASCs) are certified, freestanding entities that operate exclusively for the purpose of furnishing outpatient surgical procedures. CMDP reimburses ASCs a facility fee for services listed on Medicare's freestanding ASC coverage list. The facility fee covers all services provided by an ASC in connection with rendering surgical procedures.

- Ambulatory surgical facilities furnishing non-emergency surgical services must obtain prior authorization from the Prior Authorization Unit for scheduled ambulatory surgery.
- The PA for the ASC is separate from the surgeon's PA.
- ASC-covered surgical procedures must be billed on the CMS 1500 claim form.
- Reimbursement is based on the payment rate for that group.
- ASCs must bill the principal or primary procedure (the procedure in the highest payment group) on the first line of the CMS 1500 when multiple procedures are performed on the same recipient on the same day or at the same session.
- If an ASC does not identify the primary procedure, the CMDP system will identify the first procedure listed on the claim as the primary procedure.
- Reimbursement of the primary procedure will be at the lesser of billed charges or the capped fee for the payment group.

ASC Payment Group Rates

ASC Group	Effective 7-1-03 AZ Wage-adjusted ASC Payment
1	$331
2	$443
3	$507
4	$626
5	$713
6	$822
7	$989
8	$968
9	$1,331

EPSDT Billing Codes

The following codes are specific to billing for a well child/EPSDT office visit. Use EPSDT procedures in box 24d with any appropriate modifier, such as SL on CMS-1500 form. The appropriate V20.2, V70.0, or V70.3 ICD-9 must be on the claim or it will be denied. Indicate in section 24h by marking an "X" if services are performed under the EPSDT program. CMDP will pay if the child is eligible on the date of service.

Code	Description
	Office Visit, Health History and Physical Examination
99381	New patient, under 1 year
99382	New patient, 1 to 4 years
99383	New patient, 5 to 11 years
99384	New patient, 12 to 17 years
99385	New patient, 18 to 20 years
99391	Established patient, under 1 year
99392	Established patient, 1 to 4 years
99393	Established patient, 5 to 11 years
99394	Established patient, 12 to 17 years
99395	Established patient, 18 to 20 years
	Counseling and/or Risk Factor Reduction Interventions
99401	Approximately 15 minutes
	Tests required by EPSDT Periodicity Schedule
81000-81003	Urinalysis
83655	Lead
84030	PKU (*if not done in hospital*)
85013/85014	Hematocrit
85018	Hemoglobin
85027	Complete Blood Count
85660	Sickle Cell
86580	Tuberculosis (*Intradermal*)
86585	Tuberculosis (*Tine*)
92551	Hearing (*must be performed with calibrated machine*)
	Immunizations
90633	Hepatitis A
90634	Hepatitis A
90645	Hemophilus
90646	Hemophilus
90647	Hemophilus
90648	Hemophilus
90655	Influenza virus vaccine/split virus
90669	Pneumococcal conjugate vaccine, ployvalent
90698	Diphtheria, tetanus toxoids
90700	DTaP
90701	DTP

Code	Description
90702	DT
90707	MMR
90713	Poliovirus (IVP)
90716	Varicella
90718	Tetanus and Diphtheria TD
90720	DPT-Hib
90721	DtaP-Hib
90723	Hepatitis B & Poliovirus vaccine
90732	Pneumococcal Polysaccharide Vaccine
90740	Hepatitis B Vaccine dialysis or immunosupprossed patient
90743	Hepatitis B Vaccine
90744	Hepatitis B, pediatric
90747	Hepatitis B, dialysis or immunosuppressed
90748	HepB-Hib
90657	Influenza Virus Vaccine, Split Virus, 6 - 35 Months Dosage
90658	Influenza Virus Vaccine, Split Virus, 3 Years and Above
90659	Influenza Virus Vaccine, Whole Virus, for Intramuscular

EPSDT Tracking Forms

Providers to document all age-specific, required information related to EPSDT screenings and visits must use AHCCCS EPSDT Tracking Forms. EPSDT Forms for the various age group are found on the AHCCCS website, www.ahcccs.state.az.us, or may also be obtained through CMDP Medical Services unit by calling (602) 351-2245 or (800) 201-1795. **(Substitute forms are not acceptable.)**

Two (2) to Four (4) Days	Twelve (12) Months	Five (5) Years
One (1) Month	Fifteen (15) Months	Six (6) Years
Two (2) Months	Eighteen (18) Months	Eight (8) Years
Four (4) Months	Twenty-Four (24) Months	Ten (10) to Thirteen (13) Years
Six (6) Months	Three (3) Years	Fourteen (14) to Seventeen (17) Years
Nine (9) Months	Four (4) Years	Eighteen (18) to Twenty-One (21) Years

NOTE: All claims submitted for EPSDT services must have the completed EPSDT form attached to the CMS 1500 claim form. The PIN on the CMS 1500 claim must be for the service provider. Nurse Practitioners & Physician Assistants are required to submit claims under their own provider ID numbers in Section 33 of CMS 1500 claim form. Services provided by NP's & PA's cannot be submitted using the doctor's PIN ID.

CMDP is no longer accepting EPSDT forms if not attached to a CMS 1500 claim form.

CHAPTER APPENDIX

Provider Remittance Advice-SAMPLE

Health Insurance Claim Form (CMS-1500)-SAMPLE

UB-92 Claim Form-SAMPLE

ADA2002 Form-SAMPLE

- 2000 Version
- 2002 Version

EPSDT

- 2004 Version***

***Please use AHCCCS approved EPSDT forms. These forms are available on the AHCCCS website, www.ahcccs.state.az.us, or contact CMDP Medical Services, or your Provider Representative at (602) 351-2245 or (800) 201-1795.

Chapter 8

GRIEVANCE AND CLAIM DISPUTES

Providers have the right to grieve actions taken, or decisions made, by CMDP that have an adverse impact on the provider.

General Information

Providers should exhaust all authorized billing procedures before filing a grievance with the Comprehensive Medical and Dental Program (CMDP). It is recommended that providers do the following:

If the provider has not received a Remittance Advice identifying the status of the claim, the provider should call the CMDP Claims Unit at (602) 351-2245 or (800) 201-1795 to determine whether the claim has been received and processed.

Fourteen (14) days following claim submission should be allowed before inquiring about a claim. However, inquiry should be made well before twelve (12) months from the date of service because of the clean claim time frame and the time frame for filing a grievance.

If a claim is pending in the CMDP claims processing system, a grievance will not be investigated until the claim is paid or denied.

If all authorized billing procedures have been exhausted and the dispute remains, the provider has the right to file a grievance with CMDP.

Time Limits For Filing

A provider must institute any grievance challenging the claim denial or adjudication within twelve (12) months from the ending date of service or, for a hospital inpatient claim, within twelve (12) months from the date of discharge. The date of receipt by CMDP is considered the date the grievance is filed.

For a retro-eligibility claim, the provider must institute any grievance within twelve (12) months from the date of eligibility posting.

If CMDP takes action on a timely submitted claim fewer than sixty (60) days before the expiration of the twelve (12) month deadline or after the twelve (12) month deadline has passed, the provider will be allowed sixty (60) days from the date of the adverse action to file a grievance. The date of the adverse action is the payment date as printed on the Remittance Advice on which the claim appears.

Grievance Process

Grievances must be submitted in writing and can be mailed, hand delivered or faxed to:

Department of Economic Security
Comprehensive Medical and Dental Program
Attention: Grievance Manager
P.O. Box 29202
3225 N. Central Ave, Suite 1000
Phoenix, AZ 85038-9202
Fax: (602) 235-9146

Grievances must state in detail the factual and legal basis for the grievance and the relief requested and should include any documents to support the facts. Grievances lacking specificity may be denied.

Upon receipt of a grievance, CMDP will send a letter of acknowledgement to the provider. This letter should be retained for reference.

CMDP will thoroughly investigate all disputes using applicable statutory, regulatory and contractual provisions.

A Notice of Resolution will be rendered within thirty (30) days after the date the dispute was received, unless an extension of time has been agreed upon. This final notice of resolution will be delivered by certified mail to all parties whose interest has been adversely affected. Other interested parties are notified by regular mail.

If a grievance decision determines that the original claim denial was in error, the claim is forwarded to the CMDP Claims Unit for processing. It is not necessary for the provider to re-submit the claim.

Upholding of a grievance does not constitute a guarantee of payment nor does it constitute a waiver of all claim filing requirements and conditions because the claim may not be payable for other reasons. Claims are subject to all routine claims processing edits and audits. If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied or an edit may fail, even though the grievance was upheld for other reasons.

The final notice of resolution will include the following:

- The date of the decision, which is the date of the mailing;
- Detailed explanation of the nature of the grievance, issues involved and the provisions supporting CMDP's decision;
- Reference to the applicable statute, rule, policy or procedure;
- The providers right to request a fair hearing, and how to request the hearing, if the provider disagrees with the resolution of the claim dispute.

If the final resolution is not satisfactory to the provider, the provider may request a State fair hearing. The hearing must be requested within fifteen (15) days of receipt of the notice of resolution, for non-AHCCCS members, and within thirty (30) days of receipt of the notice of resolution, for AHCCCS members.

Requests for a fair hearing shall be submitted to:

Department of Economic Security
Comprehensive Medical and Dental Program
Attention: Grievance Manager
P.O. Box 29202
Phoenix, AZ 85038-9202

Upon receipt, CMDP will forward the request and all supporting documentation to the appropriate hearing office.

The AHCCCS or DES Office of Administrative Hearings will then review the appeal and determine whether or not a hearing is justified. If a hearing is warranted, notification of the hearing date, time and location will be provided to both CMDP and the complainant.

If a hearing is not warranted, the AHCCCS or DES Office of Administrative Hearings will issue a final decision in writing to all parties involved.

If you have any questions or would like additional information regarding grievances, appeals or fair hearings, contact the CMDP Grievance Manager at (602) 351-2245 ext 7010.

Chapter 9

FRAUD AND ABUSE

CMDP follows the Arizona Health Care Cost Containment System (AHCCCS) fraud and abuse provisions. Reported incidents of fraud and abuse will be investigated by AHCCCS and may result in legal action.

Definitions of Fraud and Abuse:

- FRAUD (by member or provider) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2)
- ABUSE (by provider) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program. (42 CFR 455.2)
- ABUSE (of member) means any intentional knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or, sexual abuse or sexual assault. (A.R.S. 46-451, A.R.S. 13-3623)
- INCIDENT means a situation of possible fraud, abuse, neglect and/or exploitation as defined in the policy that has the potential for liability.

Examples of fraud and abuse include, but are not limited to:

Falsifying Claims/Encounters
- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Falsifying Services
- Billing for services/supplies not provided
- Misrepresentation of services/supplies
- Substitution of services

Administrative/Financial
- Kickbacks
- Falsifying credentials
- Fraudulent Enrollment Practices
- Fraudulent TPL reporting
- Fraudulent Recoupment practices

Member Issues (Abuse)
- Physical or mental abuse
- Emotional or Sexual Abuse
- Discrimination
- Neglect
- Financial Abuse
- Providing substandard care
- Misdiagnosis

Member Issues (Fraud)
- Resource Misrepresentation (Transfer/Hiding)
- Residency
- Household Composition
- Citizenship Status
- Unreported Income
- Misrepresentation of Medical Condition
- Failure to Report Third Party Liability (TPL)

Denial of Services
- Denying access to services/benefits
- Limiting access to services/benefits
- Failure to refer to a needed specialist
- Underutilization

GLOSSARY

The following words and phrases in addition to definitions contained in the statute have the following meanings unless the context explicitly requires another meaning:

Acute mental health services - Inpatient or outpatient health services provided to treat mental or emotional disorders, as necessary for crisis stabilization, evaluation and determination of future service needs.

Arizona Department of Juvenile Corrections (ADJC) – The mission of the ADJC is to enhance public protection by changing delinquent thinking and behaviors of juvenile offenders committed to the Department.

Administration for Children, Youth, and Families (ACYF) –The Administration for Children, Youth and Families, within the Division of Children, Youth and Family Services, in the Department of Economic Security provides opportunities and services to families so that children at risk can grow in safe, caring environments, and to advocate for children's rights and needs.

Adjudicated child - A child adjudicated by the court as dependent, neglected or delinquent residing in a licensed foster family home or child welfare agency.

Arizona Health Care Cost Containment System (AHCCCS) – (pronounced "access") is a state agency that manages the Arizona's Medicaid Program.

Arizona Health Care Cost Containment System Administration (AHCCCSA)- The state agency which acts as the contracting and regulatory body for the state and for Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for state and federally funded health care programs.

Air ambulance - A helicopter or fixed wing aircraft licensed under the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1 as amended, to be used in the event of an emergency to transport client's or eligible persons to obtain services.

Ambulance - Any motor vehicle licensed pursuant to the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1 especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.

Ambulatory care institution - A health care institution licensed by the Arizona Department of Health Services with inpatient beds providing limited hospital services on an outpatient basis including an outpatient surgical center and an outpatient treatment center.

Ancillary services - Special services and items furnished to an institutionalized eligible client, which are separately payable in addition to the daily room and board charge. It may also be categorized as those provided by medical personnel other than physicians.

Authorization - An approval given by the designated Departmental representative or representative of the fiscal intermediary to a specific medical/dental provider to render services or items to a specific eligible client. In general, CMDP Medical Services staff gives authorization.

Casualty insurance - Liability insurance coverage related to injury due to accidents or negligence

Catastrophic coverage limitation - The financial limit as determined by the Department beyond which the contractor is not at risk to provide or make reimbursement of treatment of illness or injury to foster children which results from, or is greatly aggravated by, a catastrophic occurrence or disaster including, but not limited to, natural disaster or an act of war, declared or undeclared, which occurs subsequent to being eligible for foster care.

Child Protective Services (CPS) – A program of identifiable and specialized child welfare which seeks to: prevent dependency, abuse and exploitation of children by reaching out with social services to stabilize family life and preserve the family unit by focusing on families where unresolved problems have produced visible signs of dependency or abuse and the home situation presents actual and potential hazards to the physical or emotional well-being of children. The program shall seek to strengthen parental capacity and ability to provide good childcare.

Children's Rehabilitative Services (CRS) - A state agency that provides medical services to children meeting CRS eligibility requirements. Some CMDP members may be also eligible to receive CRS.

Clean claim – One that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claim – The invoice submitted by the medical/dental provider for reimbursement for covered services.

Coordination of Benefits (COB) – The process of using other insurance plans (families health plan, automobile or a third party's) to pay for the child's medical needs in full or in combination with CMDP.

Comprehensive Medical and Dental Program (CMDP) – The name for the Health Care program for foster children authorized by legislation and regulated by the Department of Economic Security.

Concurrent review **–** Concurrent review is a utilization management function performed by registered nurses on each inpatient admission to acute care hospitals or extended care facilities. The concurrent review process determines the appropriateness of the hospital stay and level of care. And is based on standardized review criteria.

Contract – A written agreement entered into between a person, organization or other entities and the Department to provide health care services to foster children.

Contractor – A person, organization or entity agreeing through a direct (prime) contracting relationship with the Department to provide those goods and services specified by contract in conformance with the requirements of such contract.

Covered Service – Covered services are necessary health services, which are delivered the CMDP members at the direction of the member's primary care provider (PCP). Covered services for AHCCCS are listed in this manual.

Cultural Competency - an awareness and appreciation of the customs, values and beliefs ("culture") and the ability to incorporate them into the assessment, treatment and interaction with any individual within the context of their current circumstances.

Dentist – An individual licensed to practice dentistry and/or oral surgery by the appropriate regulatory board of the State of Arizona. The term shall include such individual only when practicing within the scope of the license.

Department of Economic Security (DES) – **DES Mission Statement**
The Arizona Department of Economic Security promotes the safety, well-being, and self sufficiency of children, adults, and families.

Director – The Director of the Department of Economic Security.

Diagnostic service – Those services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

Durable Medical Equipment (DME) – Durable items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness, or injury. This definition includes, but is not limited to, such items as bedpans, hospital beds, wheelchairs, crutches, trapeze bars, and oxygen equipment.

Emergency ambulance service –

a. Emergency transportation by a licensed ambulance company of persons requiring emergency medical services.

b. Emergency medical services that are provided before, during or after such transportation by a certified ambulance operator or attendant.

Emergency medical services – Services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment of bodily functions; or

c. Serious dysfunction of any bodily organ or part.

Emergency dental services –

a. Those services necessary to control bleeding, relieve pain, and eliminate acute infections.

b. Operative procedures that are required to prevent pulpal death and the imminent lost of teeth.

c. Treatment of injuries to the teeth or supporting structures.

d. Reduction of maxillary and mandible fractures.

E.P.S.D.T. services – Early and Periodic Screening, Diagnosis, and Treatment services for person under twenty-one (21) years of age. The following meanings shall apply:

a. ***E****arly* – In the case of a foster child as early as possible in the child's life, or in other cases, as soon as a child is in foster care.

b. ***P****eriodic* – At appropriate intervals established by the Department for screening to assure that a condition, illness or injury is not incipient or present.

c. ***S****creening* – The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who may have a condition, illness or injury and the identification of those in need of more definitive study. For the purposes of the CMDP program, screening and diagnosis are not synonymous.

d. ***D**iagnosis* – The determination of the nature or cause of a condition, illness or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests and x-rays.

e. ***Treatment*** – Any type of health care or services recognized under the State Plan submitted pursuant to Title XIX of the Social Security Act.

Eyeglasses – Frames with lenses prescribed by an optometrist, ophthalmologist or other licensed medical practitioner to aid or significantly improve visual performance.

Facility – Any premise owned, leased, used or operated directly or indirectly by or for a contractor and its affiliates for purposes related to a contract; or maintained by a provider to provide services on behalf of a contractor.

Family Planning Services – Family planning services are those services provided to aid eligible persons who voluntarily choose to delay or prevent pregnancy. Family planning services include covered medical, surgical, pharmacological and laboratory benefits. Family planning services also include the provision of accurate information and counseling to allow eligible persons to make informed decisions about the specific family planning methods available. All CMDP members are entitled to family planning services.

Federal Food and Drug Administration (FDA) – FDA's mission is to promote and protect the public health by helping safe and effective products reach the market in a timely way, and monitoring products for continued safety after they are in use. Our work is a blending of law and science aimed at protecting consumers.

Fee- for-service – A method of payment to registered providers on an amount-per-service basis, up to a maximum allowable AHCCCS fee

Fee Schedule – Allowable amounts established by the Department of Economic Security for medical, dental, and psychological care for foster children.

Foster Care Provider – A home or childcare agency such as a foster home, group home, or child welfare agency, which provides care and supervision for foster children.

Foster Child – A child adjudicated by the court as dependent, neglected or delinquent or on whom the parent(s) have signed the necessary paperwork for voluntary foster care and who is residing in a licensed foster home or child welfare agency.

Generic drug – The chemical or generic name, as determined by the United States Adopted Names Council (USANC) and accepted by the Federal Food and Drug Administration (FDA), of those drug products having the same active ingredients as prescribed brand name drugs.

Grievance – A complaint arising from an adverse action, decision, or policy by a contractor, subcontractor, non-contracting provider, foster parent or the Department, presented by an individual or entity as specified by AAC Article 6 and Article 9, and CMDP policy.

Hearing aid – Any wearable instrument or device designed for, or represented as aiding or compensating for impaired or defective human hearing, and any parts, attachments or accessories of such instrument or device.

Hearing aid evaluation – The application and interpretation of a battery of tests by an otolaryngologist, otologist, other licensed medical practitioner or audiologist to determine if amplification may be advantageous to an individual's hearing and what parameters of amplification are required to obtain a satisfactory result.

High-risk pregnancy – A pregnancy complicated by diabetes mellitus, hypertension, previous history of multiple stillborns, expected multiple birth, or a foster child under age 18 years.

Hospital – A health care institution that is licensed by the Department of Health Services pursuant to A.R.S. Title 36, Chapter 4, Article 2, as a hospital, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of such certification.

Identification card – A card for each foster child issued by the Department to establish the identity of the child eligible for the covered services.

Inpatient – A person who has been admitted into a hospital, rehabilitation, or skilled nursing facility for bed occupancy for purposes of receiving inpatient services. A person will be considered an inpatient when formally admitted as an inpatient, i.e. when admitted for a period of more than 23 hours or through the census hour.

Inpatient days – The number of days of care charged for hospital or skilled nursing facility services.

Inpatient hospital services – Those services and items furnished by the hospital for the care and treatment of inpatients under the direction of a physician or dentist.

Legal guardian, conservator, executor, or public fiduciary – A person appointed by a court or other protective order to be in charge of the affairs of a minor or incapacitated person.

Legend drugs – Those drugs that under Federal or State law or regulations may be dispensed only by prescription.

Long term care – Room and board services ordinarily provided in a licensed nursing care institution, licensed supervisory care facility or certified adult foster care facility.

Medical/Dental Provider – Any person, institution or entity, which provides covered services to an eligible foster child under the program.

Medicaid – A Federal/State program authorized by Title XIX of the social Security Act, as amended, which provides federal matching funds for a medical assistance program for recipients of federally aided public assistance, SSI benefits and other specified groups. Certain minimal populations and services must be included to receive FFP (federal financial participation); however, states may optionally include additional populations and services at State expense and also receive FFP.

Medical record – A single, complete record kept at the site of the client's primary care provider that documents the medical services received by the client, including inpatient discharge summary, outpatient and emergency care.

Medical services – Services pertaining to medical care that are performed at the direction of a physician, on behalf of clients or eligible persons by physicians, dentists, nurses, or other health related professional and technical personnel.

Medical supplies – Consumable items which are designed specifically to meet a medical purpose.

Medically necessary – Those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law to:

a. Prevent disease, disability and other adverse health conditions or their progression, or
b. Prolong life.

Medically necessary sterilization – Sterilization to:

a. Prevent progression of disease, disability or adverse health conditions:
b. Prolong life and promote physical health.

Minor – A person under eighteen (18) years of age.

Member – This definition refers to: person who is enrolled with CMDP.

Non-PPN Providers – Health care providers who are registered but have not applied to CMDP to provide covered services to CMDP members.

Nursing services – Those services that are performed by or under the supervision of a registered nurse at the direction of a license practitioner.

Occupational therapist – A person who has completed equivalent educational requirements and work experience required for a certificate of occupational therapy.

Ophthalmologist – A licensed medical practitioner who specializes in the diagnosis and treatment of the eye and its related structures.

Optometrist – A person registered with the State medical board to practice optometry.

Orthodontic condition – A clinically obvious physical abnormality of tooth and/or jaw relationships.

Orthopedic devices – Supportive or corrective devices used for treatment of musculoskeletal abnormality or injury.

Otolaryngologist – A licensed medical practitioner whose practice is limited to the specialty of conditions or disease of the ear, nose, and throat and who qualifies as a specialist in those areas.

Otologist – A physician who limits his practice to the specialty of conditions and diseases of the ear and who qualifies as a specialist in this are.

Outpatient health services – those preventatives, diagnostic, rehabilitative or palliative items or services that are ordinarily provided in hospitals, clinics, physician's offices and rural clinics, by licensed health care providers by, or under the direction of a physician or practitioner, to an outpatient.

Palliative services – Those services required reducing the severity or relieving the symptoms of a condition, illness, or injury.

Primary Care Provider (PCP) - This term is used interchangeably with primary care physician. The CMDP PCP is a physician who is responsible for the overall management of a member's health care. PCPs may include, but not limited to; a physician who is a family practitioner, general practitioner, internist, pediatrician, obstetrician, or gynecologist; a certified nurse midwife or nurse practitioner; or under the supervision of a physician, a physician's assistant.

Pharmaceutical services – Medically necessary drugs prescribed by a practitioner, or other physician or dentist upon referral by a primary physician.

Pharmacist – A person licensed as a pharmacist under A.R.S. Title 32, Chapter 18.

Pharmacy – An establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist and which is registered pursuant to A.R.S. Title 32, Chapter 18.

Physical therapist – A person registered to practice physical therapy.

Physical therapy services – Those services provided by or under the supervision of a physical therapist.

Physician's Current Procedural Terminology (CPT) – The manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language that will accurately designate medical, surgical, and diagnostic services.

Physician Services – Services provided within the scope of practice of medicine or osteopathy as defined by State law, or by or under the personal supervision of an individual licensed under State law, to practice medicine or osteopathy, and excludes those services routinely performed and not directly related to the medical care of the individual foster child. The term shall also include a Christian Science practitioner recognized by the Mother Church and listed as such in the "Christian Science Journal."

Practitioner – Physician's assistants and registered nurse practitioners who are certified and practicing in an appropriate affiliation with a primary physician as authorized by law.

Preferred Provider Network (PPN) – Health care providers participating with CMDP to provide covered services to CMDP members. PPN providers have fewer prior authorization requirements than non-PPN providers and clean claims are paid promptly.

Pre-payment – An arrangement in which a contractor agrees to provide health care services for a prospective, predetermined, periodic, fixed subscription premium.

Prescription – An order to a provider for covered services, which is signed or transmitted by a provider authorized to prescribe or order such services.

Preventative health care – Those health care activities aimed at protection against, and early detection and minimization of, disease or disability.

Prior authorization – The process by which the Department will advance whether a covered service that requires prior approval will be reimbursed based upon the accuracy of the information received and substantiated through concurrent and/or retrospective medical review.

Provisional prior authorization – Is a temporary authorization given, pending the receipt of required documentation to substantiate compliance with CMDP.

Prosthesis – An artificial substitute for a missing body part including, but no limited to, an arm, leg, eye, tooth, etc.

Psychologist – An individual certified by the State Board of Psychologist Examiners.

Quality Management – A methodology used by professional health personnel that assess the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Radiological services – Professional and technical x-ray and radioisotope services ordered by a physician or other licensed health professional for diagnosis, prevention, treatment or assessment of a medical condition. Radiological services include portable x-ray, radioisotope, medical imaging and radiation oncology.

Regional Behavioral Health Authority (RBHA) –(pronounce REE-BAH). These entities are contracted by the Arizona Department of Health Services (ADHS) to provide Title XIX covered behavioral health services to eligible members.

Referral – The process whereby a foster child is directed by a primary care provider to another appropriate provider or resource for diagnosis or treatment.

Rehabilitation services – Physical, occupational, speech, and respiratory therapy, audiologist services and other restorative services and items required to reduce physical disability and restore child to an optimal functional level.

Routine services – Those services and items included in an impatient provider's daily room and board charge.

Routine physical examinations – Medical examinations performed without relationship to treatment or diagnosis of a specific condition, illness or injury.

Service area – The geographical area designated by the Department within which a contractor shall provider, directly or through subcontract, covered health care services to foster children.

Service location – Any location at which a foster child obtains any covered health care service.

Service site – The location at which foster children shall receive services from a primary care provider.

Specialist – A Board eligible or Certified physician who declares himself or herself as such and practices a specific medical specialty.

Social Security Administration (SSA) – An agency of the Federal Government responsible for administering certain titles of the Social Security Act, as amended.

Specified relative – A non-parent caretaker of a dependent child who is a grandparent, great-grandparent, brother, or sister of whole or half blood, aunt, uncle, or first cousin. (A.R.S. § 8-501.A.11).

Skilled Nursing facility – A health care institution, which is licensed by the Department of Health Services as a skilled nursing facility.

Speech therapist – A person who has been granted the Certificate of Clinical Competence in the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience required for such a certificate, and who is licensed by the state.

Supplemental Security Income (SSI) – Supplemental income under Title XVI of the Social Security Act, as amended.

Third party – Any individual, entity or program that is, or may be liable to pay all or part of the medical cost of injury, disease or disability of a CMDP foster child.

Third party liability – The resources available from a person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a CMDP eligible foster child.

Therapeutic services – Those curative services required for treatment of a condition, illness or injury and includes acute, chronic and emergency care.

Treatment plan – That portion of the authorization process, which requires that the attending physician and other professional allied health personnel involved in the care of an eligible foster child establish and review periodically a plan of treatment and care for each eligible foster child.

UB 92 – A universal billing form for claims. Hospital inpatient, outpatient and emergency room claims are filed on this form. The UB 92 is not to be confused with a "universal claims form" for filing pharmacy claims. Skilled nursing facilities also use the UB 92 for claims submissions.

United States Adopted Names Council (USANC) – The purpose of the USANC is to serve the health professions in the United States by selecting simple, informative, and unique nonproprietary names for drugs by establishing logical nomenclature classifications based on pharmacological and/or chemical relationships.

Utilization control – The overall accountability program encompassing quality assurance and utilization review.

Utilization management – A methodology used by professional health personnel that assesses the medical indications, appropriateness and efficiency of care provided.

Vaccines for Children (VFC) – The VFC program was established in 1993 to serve children defined as "federally vaccine eligible" under section 1928 (b) (2), which includes both "uninsured" and "Medicaid eligible" children. American Indian, Alaskan Native children and children whose insurance does not cover immunizations are also eligible for VFC. States will continue to receive federal funding for reduced-price vaccines under this program.